S. Hrg. 114–413

RISKY BUSINESS: EXAMINING GAO'S 2015 LIST OF HIGH RISK GOVERNMENT PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

FEBRUARY 11, 2015

Available via the World Wide Web: http://www.fdsys.gov/

Printed for the use of the
Committee on Homeland Security and Governmental Affairs

U.S. GOVERNMENT PUBLISHING OFFICE

94–274 PDF WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

RON JOHNSON, Wisconsin *Chairman*

JOHN MCCAIN, Arizona
ROB PORTMAN, Ohio
RAND PAUL, Kentucky
JAMES LANKFORD, Oklahoma
MICHAEL B. ENZI, Wyoming
KELLY AYOTTE, New Hampshire
JONI ERNST, Iowa
BEN SASSE, Nebraska

THOMAS R. CARPER, Delaware
CLAIRE MCCASKILL, Missouri
JON TESTER, Montana
TAMMY BALDWIN, Wisconsin
HEIDI HEITKAMP, North Dakota
CORY A. BOOKER, New Jersey
GARY C. PETERS, Michigan

KEITH B. ASHDOWN, *Staff Director*
PATRICK J. BAILEY, *Chief Counsel for Governmental Affairs*
GABRIELLE A. BATKIN. *Minority Staff Director*
JOHN P. KILVINGTON, *Minority Deputy Staff Director*
TROY H. CRIBB, *Minority Chief Counsel for Governmental Affairs*
LAURA W. KILBRIDE, *Chief Clerk*
LAUREN M. CORCORAN, *Hearing Clerk*

CONTENTS

WITNESSES

WEDNESDAY, FEBRUARY 11, 2015

APPENDIX

RISKY BUSINESS: EXAMINING GAO'S LIST OF HIGH-RISK GOVERNMENT PROGRAMS

WEDNESDAY, FEBRUARY 11, 2015

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in room SD–342, Dirksen Senate Office Building, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senators Johnson, Lankford, Ayotte, Ernst, Sasse, Carper, McCaskill, Baldwin, Heitkamp, and Peters.

OPENING STATEMENT OF CHAIRMAN JOHNSON

Chairman JOHNSON. This hearing will come to order.

I want to welcome everyone. I appreciate my colleagues coming here and all the members of the audience and, of course, Comptroller General Eugene Dodaro and other members of the Government Accountability Office (GAO).

This is an important hearing. There is a reason this is the third hearing that we are having in this Congress on this Committee. The good work that GAO has done is demonstrated by the fact over the last 2 years, just recommendations implemented from previous High-Risk Lists have generated $40 billion of savings over the last 2 years. I mean, that is a remarkable figure.

Today, we are going to be talking about the update to the list. There is some good news. I am happy to report that the Department of Homeland Security (DHS) management has made solid progress and there are some prospects of DHS coming off that list. We are looking forward to that. There has been progress made in terms of the Department of Defense (DOD) contract management, progress made with the Food and Drug Administration (FDA's) oversight of medical devices.

Unfortunately, there has been some expanded scrutiny—tax code enforcement and fraud. I appreciate the fact that the GAO is pointing out the fact that cybersecurity is a real issue, a real threat, and that is a top priority of this Committee, to start taking pieces of legislation or be involved in the passage of legislation that will address the first step in providing some measure of additional cybersecurity, and that would be information sharing. So, I appreciate that.

I hate to report that there are some new areas added. Information technology (IT) acquisition—that is really not much of a surprise, but it is very disappointing to hear that Veterans Affairs

(VA) Health Care, has been added to this, and this hits pretty close to home with both Senator Baldwin and myself.

We have a facility in Tomah. Over the last couple of years, we have lost three veterans to the system. Two died with deaths related to potential opiate drug over-prescription, and not even a month ago, a 74-year-old veteran—I am not a doctor, but pretty obvious stroke symptoms sat and waited in a waiting room for 3 hours to be treated, probably had a stroke, was wheeled into an examination room, waited another 45 minutes, had a massive stroke, was finally ambulanced to a different hospital. The CT scanner was apparently not operational, so they could not administer anticoagulant drugs, and this gentleman died 2 days later.

So, it is noteworthy to understand that GAO has been making recommendations to the Veterans Health Care System for a number of years. There are more than 100 recommendations that have not been implemented, about 80 percent of the recommendations.

So, certainly what I would like to get out of this Committee, out of this hearing and hopefully out of Committee action, is coming up with some kind of method, some kind of control to make sure that these good recommendations that save the taxpayer so many dollars, that could potentially save lives, are actually implemented. I mean, that has to be a top priority of this Committee. Let us utilize the guidepost of the GAO High-Risk List and the other good work they do and let us make sure these recommendations are finally implemented at the agency level. It will save money. It will save lives.

So, with that, I would like to turn it over to our Ranking Member, Senator Carper.

OPENING STATEMENT OF SENATOR CARPER

Senator CARPER. Thank you, Mr. Chairman. Thanks for convening us today.

And, to Gene Dodaro and to the many members of your team that are in the audience and may be listening or watching outside of the building, we want to just say a big thank you to all of them for giving us a great to-do list. My wife is a big believer in to-do lists, and every morning, I go down to the kitchen and there on the island in the kitchen, usually is a to-do list. Sometimes it is for her. Sometimes it is for me. And, what you have provided, you and your colleagues at GAO have provided us, is an incredibly important to-do list, and you do this every 2 years. We take that responsibility on your part seriously and we take the responsibility just as seriously for ourselves.

It is interesting how you can make progress in addressing any number of the areas that need to be addressed within that to-do list you are providing for us. We can hold a hearing, and over the years, we have been able to make real progress just by scheduling a hearing and bringing folks to this table, in some cases, folks who are in charge of acquisitions at the Department of Defense for weapons systems. Just hold a hearing. In other cases, we send letters, and they can have an amazing effect.

We not only will introduce legislation, we will simply call the Secretary of the Department or the senior person within the Department and say, we want to meet with you and here is why. And,

you and your team are complicit in a very positive way in all of that.

For those of you who have joined us, we had a press conference here early on and I talked about from time to time people say to me, "I do not mind paying taxes. I just do not want you to waste my money." I do not want to waste their money, either, and this Committee is committed to making sure that we continue to fight. It is like whack-a-mole, and the government is so big, and there are so many people trying to defraud our government for money.

I have an entire statement I want to make part of the record,[1] but I just want to say, the kind of passion and commitment that we have brought to addressing the entire to-do list remains. Tom Coburn is gone, but that spirit that he brought to this Committee for all those years is still being nurtured by me and, I think, by Ron, and by a new Member from Oklahoma. A lot of work to do, and we are going to work it together.

I will say one other thing that I think bears repeating. I am a big believer in leverage. When I chaired with Tom and led a Subcommittee of this Committee, we tried to be effective in addressing waste, fraud and abuse in government, and we found that we could be a lot more effective as a Subcommittee or this full Committee if we partnered with you and with your team. We found that we could be more effective if we would partner with the literally dozens of Inspector Generals (IGs) across the Federal Government. We found that we could be more effective if we would partner with the Office of Management and Budget (OMB), with the nonprofit organizations that are committed to reducing waste in government, and it works. It actually works.

It is a little bit like changing the course of an air craft carrier, but if you stick with it, you do not give up, you can change the course of an air craft carrier, and we can change the course of our government and improve the service that we provide for the people of this country.

So, we look forward to hearing from you, anxious to watch you read your notes yet again—actually, he never reads his notes, and is one of the most amazing people I have ever seen testify in the Congress. I always say this and hope maybe it will spook him so that he will forget where he is. [Laughter.]

I remember Winston Churchill used to give speeches before the House of Parliament and he would, like, memorize his speeches, and one day he was giving a speech, a terrific speech—you know how good he was—and he forgot his speech and he lost his way. So, I keep waiting for that to happen with you—— [Laughter.]

But I have been calling all these years, Gene, and you never do, so I do not want to jinx you today, but thanks very much for being here and talking with us and we look forward to this conversation.

Chairman JOHNSON. That is that accounting background, right?

I should have mentioned earlier, I do have a formal opening statement that I would like to enter into the record.[2] Without objection, so ordered.

---

[1] The prepared statement of Senator Carper appears in the Appendix on page 40.
[2] The prepared statement of Senator Johnson appears in the Appendix on page 39.

It is the tradition of this Committee to swear in witnesses, so Mr. Dodaro and any other GAO employees that might assist in the testimony, please rise. Raise your right hand.

Do you swear the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God?

Mr. DODARO. I do.
Ms. BASCETTA. I do.
Ms. DRAPER. I do.
Mr. HERR. I do.
Mr. MAURER. I do.
Mr. MIHM. I do.
Mr. POWNER. I do.
Mr. WHITE. I do.
Mr. WILSHUSEN. I do.

Chairman JOHNSON. Please be seated. Mr. Dodaro.

TESTIMONY OF HON. EUGENE L. DODARO,[1] COMPTROLLER GENERAL OF THE UNITED STATES, U.S. GOVERNMENT ACCOUNTABILITY OFFICE; ACCOMPANIED BY CYNTHIA BASCETTA, MANAGING DIRECTOR, HEALTH CARE; DEBRA A. DRAPER, DIRECTOR, HEALTH CARE; PHILLIP HERR, DIRECTOR, PHYSICAL INFRASTRUCTURE ISSUES; DAVID MAURER, DIRECTOR, HOMELAND SECURITY AND JUSTICE; J. CHRISTOPHER MIHM, MANAGING DIRECTOR, STRATEGIC ISSUES; DAVID A. POWNER, DIRECTOR, INFORMATION TECHNOLOGY; JAMES WHITE, DIRECTOR, STRATEGIC ISSUES; AND GREGORY WILSHUSEN, DIRECTOR, INFORMATION TECHNOLOGY

Mr. DODARO. Thank you very much, Mr. Chairman. Good morning to you, Ranking Member Senator Carper, and Members of the Committee. I am very pleased to be here today to discuss the update to GAO's High-Risk List.

We provide this update with the beginning of each new Congress to help the Congress set its priorities for oversight and to help the Administration focus on areas that we consider to be of highest risk for either fraud, waste, abuse, or mismanagement, or in need of broad-based transformation across the government.

This year, we are reporting solid, steady progress in the vast majority of the High-Risk Areas that we have had on the list to date. We are also providing ratings for the first time against each High-Risk Area's status and progress getting off the list.

In order to get off the list, High-Risk Areas need to meet five criteria. They need to have top leadership commitment. They need to have the capacity, the resources, and the people with the right skills to get off the list. They have to have a good corrective action plan that goes to the root cause of the problems. They have to have a monitoring effort with interim milestones and metrics to make sure they are making progress. And then they have to demonstrate that they are actually beginning to fix the problem. They do not have to have it 100 percent fixed to get off the list, but they have to have tangible progress that they are on the right path and are actually fixing the problem.

[1] The prepared statement of Mr. Dodaro appears in the Appendix on page 43.

Now, of the 30 areas that were on the list based on our last update, 18 of those areas have at least partially met each of the five criteria for coming off the list. Eleven of those areas have fully met at least one or more of the criteria and partially met the others. So, there is good, steady progress as we report.

In two areas, we report enough progress that we are actually narrowing the scope of the High-Risk Area. First, in FDA's oversight of medical devices, in the area of recalls, we were concerned that they were not consistently applying recall criteria, actually ensuring that the recalls were effective, and did not analyze recall data over time to identify potential trends that warranted some alerts to the industry. They are now doing that. They have analyzed 10 years of data. They are ensuring greater consistency in having recalls. They are documenting whether the recalls have occurred and were effective.

And, also, we have seen progress in their ability to process new device requests. In the past, they were slow to implement legislation that provided a dual-track process where certain devices that were similar to those on the market could go to an expedited review, but new devices that passed the highest risks needed to go through a more stringent review. They were slow to implement the Act. They have now corrected that and they are on track to implement the legislation by this year.

They still have issues in ensuring the adequacy and the safety of medical products and devices in a global marketplace. Right now, 80 percent of the active ingredients for prescription drugs, 40 percent of finished drugs, and about half of medical devices come from about 150 countries around the world. So we have encouraged them to move from an oversight process focused on overseeing domestic production to overseeing what is now a global marketplace for drugs and devices, and also to focus on drug shortages. They still have work to do in that area, and many of these are life-sustaining and life-saving drugs that are of concern.

We have also seen enough progress in the contract management area at DOD to warrant narrowing that area, particularly as it relates to contracting tools and techniques. This is to ensure that they do not use overuse undefinitized contracts and time and materials contracts, which are more risky to the government. They also plan to ensure more competition and they have better oversight over those processes now. But, the remaining areas they need to fix are: (1) service acquisitions, (2) ensure they have an acquisition workforce commensurate with the challenges associated with that, and (3) they have to make improvements in operational contracting where they are using contracting to support military operations in the theater.

We have also noted improvements in the Department of Homeland Security management functions. That area has been on the list for a number of years. We are very pleased with the leadership commitment of that Department and the Secretary, Deputy Secretary, and Under Secretary for Management. They have a very good corrective action plan and they are starting to make progress. They have received clean opinions on their financial statements for 2 years in a row right now, but there are other areas that they need to fix. They have fixed about 9 of the 30 areas that we have

identified and they have agreed it needs to be fixed. So, they have to fix the remaining 21 areas, but they have a good plan. They just have to execute the plan over a period of time, particularly in the acquisition area and some remaining areas in financial management, particularly on internal controls.

Now, we are adding two new areas. First is VA's provision of health care services to our veterans. We have been very concerned about this area and really have five overarching themes of concern. One is ambiguous policies and inconsistent processes over time. The fact that they have inadequate oversight and accountability mechanisms. They have information technology challenges that they have to solve. There is inadequate training of VA staff and unclear resource needs and allocation processes. And, I can talk more about this in the Q and A session.

Congress has passed legislation providing them with additional money, $15 billion, but the legislation has to be implemented effectively. And, as Senator Johnson has mentioned, we have over 100 recommendations that we have made to the VA that have not yet been fully implemented and they need to do so.

The other area, new, that we are adding is IT acquisitions and operations. The report that we are providing today outlines a litany of failed IT modernizations in the government, where hundreds of millions of dollars, and in some cases billions of dollars, have been spent, but the effort has been terminated or failed. There is even a longer list of areas that have cost overruns, schedule slippages, or provide less functionality than initially intended, thereby not really improving operations in the agencies that much.

Congress passed some legislation late last year, the Federal Information Technology Reform Act, that gives Chief Information Officers (CIOs) additional authorities and puts in place in statute a number of good practices that we have identified, but it has to be implemented effectively. Typically, we have found these areas lack discipline and requirements management and project management to actually manage IT acquisitions effectively.

We also talk about operations. Fifty-eight of the $80 billion that is spent each year is on operations and support of legacy systems that we believe may not be needed, may be duplicative, and may no longer be performing as efficiently and effectively as possible, particularly given opportunities in the marketplace to get IT services at less cost.

In this new High-Risk Area, over the last 5 years alone, we have made 737 recommendations and only 23 percent have been fully implemented. So, again, Congress has made efforts in VA and IT, but the efforts need to be monitored. Congressional oversight is imperative, in my opinion. And, the agencies need to make reforms.

We are expanding two areas. One is in tax administration. We had been focused on the next tax gap, which the annual latest estimate is $385 billion between taxes owed and taxes paid. But, identity theft has become a growing problem, so we are adding that to the list. The Internal Revenue Service (IRS) was successful in stopping about $24 billion last year, but they missed, on their estimate, about $5.8 billion in fraud. We have some potential action to remedy this situation and recommendations for the Congress and the IRS we can talk about in the Q and A session.

The last area is cybersecurity. We initially designated computer security across the entire Federal Government at High-Risk in 1997. In 2003, we added critical infrastructure protection, because most of the computer assets are in the private sector. But, now, we are adding privacy to the High-Risk issue as more personally identifiable information (PII) is being collected. The number of incidents at the Federal Government level involving inadequate controls over IT, controls over the personally identifiable information, has more than doubled in the last 5 years. There have been a lot of high-profile incidents in the private sector, as well. Privacy law was passed in 1974. We believe it needs to be updated to provide greater controls, and we can talk about our recommendations.

In closing, I would like to recognize that the progress that we did note in many of the areas was due to the Congress taking action, passing legislation. For example, five bills alone in the cybersecurity area, but more is needed, as we have talked about, in that area. Top leaders in the agencies and OMB have been focused on our High-Risk list. I have regular meetings with OMB Deputy for Management Beth Cobert and top officials in the agencies to discuss the High-Risk Areas and what needs to be done specifically to get off the list and to make continued progress.

I appreciate the opportunity to be here today to discuss this further and look forward to working with this Committee. Fixing these high-risk problems as the potential to save billions of dollars, improve services to the public, and enhance trust and confidence in the Federal Government's activities.

So, thank you very much for the opportunity to be here. I would be happy to answer questions.

Chairman JOHNSON. Well, thank you, Mr. Dodaro.

Let me start with an apology. You are so familiar to me—you are the face of the GAO—I forgot to introduce you to those that may not be as familiar, so let me do it right now.

Eugene Dodaro has been the Comptroller General of the U.S. Government Accountability Office since 2010 and has more than 40 years' experience at the agency, including as Acting Comptroller General, Chief Operating Officer, and Head of the Accounting and Information Management Division. So, you have extensive knowledge and we certainly appreciate your service.

Let us talk dollars. We are both accountants. I was really pleasantly surprised at the answer I got when I asked for how much have we saved just in the last couple of years and the figure was $40 billion. I will not investigate that. We will take you at your word.

If we were to implement the recommendations on the current High-Risk List—I realize this is impossible to probably answer, but I would like you to take a stab at it—what would you think might be the potential savings?

Mr. DODARO. Well, I will just give you two benchmarks that would give you some idea of the magnitude of the potential savings. Improper payments this past year alone in the Medicare program were $60 billion. In Medicaid, it was over $17 billion. And, in the Earned Income Tax Credit, it was over $14 billion. So, any effort to reduce the size of those improper payments and ensure better

integrity in the payment process can yield billions, if not more, in savings, right in those three programs alone on the list.

The DOD weapons acquisitions area has hundreds of billions of dollars in potential investments. Some of the $40 billion in savings have come from identifying weapons systems that were not ready to go into production, that would have wasted funds, and DOD or the Congress made decisions to reduce the procurement orders for those areas.

And, let us take the tax gap alone. Any amount reducing one percent the tax gap—right now, there is 84 percent compliance, so we have about 16 percent noncompliance in the country, and it goes across the range of different taxpayers, whether it is business or individual taxpayers or small businesses. Any one percent increase in collection of taxes owed is $4 billion right there.

So, there is lots of money on the table that is not being collected that should be collected. There is money being paid that should not be paid. So, there are plenty of opportunities to save money in these areas.

And, I am particularly concerned that in the Medicare and Medicaid area, because they are the fastest growing Federal programs, if the Centers for Medicare and Medicaid Services (CMS) does not get a better handle on these areas, that problem will get a lot worse before it will get better.

Chairman JOHNSON. Well, my back-of-the-envelope calculation, you are already talking about close to $100 billion just right then and there.

I know Senator Carper talked about Senator Coburn earlier using GAO reports. Senator Coburn always used to publish the "Waste Book," unfortunately, after the money was spent. My goal would be, let us publish a "Waste Book" before the money is spent, and again, you gave us the guideposts for doing that.

Talk about implementation. I mean, what can we do? What could this Committee potentially do to induce, might I say, force implementation, because you have so much money at stake. And, like I say, it is not just money. Take a look at the VA. It could be lives. I mean, what can we do to prompt, induce, force as full implementation of your recommendations as possible?

Mr. DODARO. I will give you an example of one of the things that I have done that I think could be replicated in the Congress to really induce more progress. One is, since I became Comptroller General, I went to OMB and I said, look, you have real serious problems here across the spectrum of the Federal Government. During the Bush Administration, GAO started having meetings with OMB and the agencies on the High-Risk List, but it was usually at the Assistant Secretary level and below.

And I said, look, if you get the head or the deputy of the agency here to the meeting and the Deputy Director for Management is at the meeting, I personally will participate in those meetings to focus on what needs to be done to make improvement. We have been doing that for the past couple of years. I attribute raising the elevation of that level to the top agency leaders in the agency to the degree of progress that we have seen over the past several years.

I believe engagement with those top officials, whether it be in a hearing or it be in a private meeting, it be with correspondence or

other efforts, with the Congress and with the agency, is really important.

The second major thing Congress could do, on the High-Risk List, you will see an asterisk beside every area that requires Congress to act and pass legislation in order to rectify the High-Risk Area. Financing the Nation's surface transportation system is an example. Postal Service reform is another example in that area. And, there are many other areas on the High-Risk List where Congress is an integral part of actually fixing the problem, and we have noted that so that the Congress could focus on those areas.

So, those are two real fundamental things that I think are very important, and ensuring continuity over time so that progress can be achieved.

One of the reasons I was very convinced to put VA Health Care and IT acquisitions and reform on those areas is because, I believe neither one will be fully resolved during this Administration's watch and will have to be continued and sustained into the next Administration. And, so, it is very important to have that continuity to focus on these problems.

Chairman JOHNSON. Well, certainly, one of the things we can do with this Committee is hold those hearings. We will work very closely with you to schedule those hearings and have you have a seat at the table as we are talking to those agencies.

Mr. DODARO. We would be happy to.

Chairman JOHNSON. I do want to, in my remaining time, I want to drill down in terms of the VA Health Care System. A hundred recommendations. Over what time period have you been issuing those recommendations? Why have they not been implemented? And, can you just kind of speak to the major recommendations that you think really need to be prioritized for implementation.

Mr. DODARO. Sure. I will ask my colleague, Debbie Draper, who is focused on that work, to come to the table to help me answer the questions, but I will start.

We first started reporting on this problem in the year 2000, so the recommendations have been made over a number of years. And, I might point out, in a number of these cases, VA agreed to implement the recommendations, but they were not being implemented over time effectively. I met with Secretary Eric Shinseki when he was there, talked about the need to implement the recommendations. I have just met with Secretary Robert A. McDonald and he agreed to make it a priority to implement the recommendations.

Most of them are on access to care issues, where they do not have good scheduling systems put in place. The IT system that supports the scheduling system is about 30 years old. One of the IT failures that we point out in our report explained that after 7 or 9 years and over $200 million, they terminated their effort to upgrade and modernize that system.

They do not have good data in a lot of areas to compare whether it is cheaper for certain particular services to give treatment in a VA facility or send the person to a non-VA facility, and this is really important because Congress has just given them $10 billion to make those decisions. They do not have good information to make well-informed decisions in those areas.

But, Debbie has been doing a terrific job. I will ask her to elaborate a little bit more.

Chairman JOHNSON. Please.

Ms. DRAPER. Thank you. So, we made 167 recommendations over the past 5 years, and there are actually more prior to the 5-years, but more recently, it is 167. Just over 20 percent of those have been completely implemented and closed. So, there is a large number of recommendations, as Gene talked about. There are a lot related to access to care. And, it is not just the policies. It gets back to the five broad buckets of why we included VA Health Care in the High-Risk List.

Inconsistent processes that play out at the local level—you have a lot of variation at the local level, and this is really attributed to ambiguous policies, which are widely interpreted. Policies do not tend to be standardized processes across the VA Medical Centers (VAMC). We also see certainly inadequate oversight and accountability and, for example, VA tends to rely on self-reported compliance with policies, and that information is often not verified. So, when we go in, we look at those compliance issues and, contrary to what the facilities have reported, most of the times, they are not in full compliance with the policy. So, there are a lot of different areas, but there are a large number of recommendations that remain open.

Chairman JOHNSON. Well, thank you. We will work very closely with you in terms of trying to push and prod the VA to implement those recommendations as rapidly as possible, so we look forward to working with you. Senator Carper.

Senator CARPER. Thank you, Mr. Chairman.

You mentioned how large the tax gap is, and I think the number you mentioned, Gene, was $385 billion, is that correct?

Mr. DODARO. Yes. That is the net amount. There is a gross amount, and then IRS expects to collect so much. Yes.

Senator CARPER. Is that money that is owed in one-time money, or is it money that is lost on a recurring basis?

Mr. DODARO. It is the latest estimate based upon tax year 2006. One of the reasons that the IRS has been on the list for many years, and the original list in 1990, was tax administration, where they were not measuring the tax gap. And, so, after a number of years and prodding by us and the Congress, they finally started measuring it. It is expensive to measure it, so that is the latest estimate. But, it is an annual estimate.

Senator CARPER. All right. The Commissioner of the IRS is a fellow named John Koskinen, whom you probably know. Have you met with him?

Mr. DODARO. I have worked with John in many areas over the years. He used to be the Deputy for Management at OMB. Actually, John and I worked to put in the Chief Financial Officer structure into the government and on legislative initiatives to actually create CIOs across the government and fixing the Y2K problem. So, I have much knowledge of working with John and I have met with him in his new capacity.

Senator CARPER. That is good. He is a very impressive leader, and I am hopeful he is going to provide wonderful leadership at the IRS.

He testified before the Finance Committee last week, and later I met with him in my office. One of the things that he mentioned to me is that for every dollar that we invest in the IRS and their people and their technology, they generate roughly $10 worth of revenue. And, if you look at the amount of money that we provide for the IRS to do their job now, we actually provide less than we did a few years ago. And, as you suggest, we are leaving about $400 billion of money on the table of money that is not being collected. Would you just care to comment on his observation?

Mr. DODARO. Yes. We have reported—in fact, we rate IRS as "not met" in the capacity area to fix this problem, largely because of some of the resources and the uncertain budget environment in this area going forward. Now, that being said, though, we also have a number of recommendations that they need to look at and evaluate the return on investment that they are getting from different enforcement efforts, and they could do more with the resources that they have been given and prioritize those efforts. So, we have a number of recommendations in those areas.

But, that is an area that I believe needs attention to make sure that they have the resources necessary to be able to improve collections. They have been having budget cuts and they have been given increased responsibilities in the Affordable Care Act and a number of other——

Senator CARPER. And, the other thing they have been given is a tax code that is not made more simple every year, but generally made more complex. And, we muck around with it and change it at the last hour or do not change it and we make it difficult for them to actually provide the information to people who want to file their taxes in a timely way. There is plenty of work to be done here, but a good deal of that work is to be done by my colleagues, not just on this Committee, but our colleagues in the House and Senate working with the Administration, and thank you.

Mr. DODARO. And there are some things that Congress could do to help IRS. One thing to do would be to increase the requirement for electronic filing. Another would be to give them additional math authority where they could fix errors right on the spot rather than generating and spending a lot of time over those errors. So, we have a lot of recommendations. Obviously, simplifying the tax code would be tremendously helpful.

Senator CARPER. They have also been asking for legislation that would enable them to better ensure some quality in terms of capability of the people who help prepare returns and file returns.

Mr. DODARO. Yes.

Senator CARPER. I think that is a very large problem.

Mr. DODARO. Yes. We have made that recommendation. We studied the use of that in Oregon. Oregon was actually piloting it for their own State and they found that making certification, training requirements for paid tax preparers increased their collections and we recommended that IRS do it. They went forward and the courts have ruled they did not have the authority to do it, and so it is really in Congress' hands right now to give them that authority. We continue to recommend that would be a good thing to do.

About 60 percent, of the people go to paid tax preparers. We have done work in the past where we have sent undercover teams in to

paid tax preparers, and the last time we did it, three out of ten were making mistakes and particularly errors in the Earned Income Tax Credit area.

Senator CARPER. Good. Thank you for that.

You mentioned the number of items that have been listed on the High-Risk List for years, and I think there are hundreds that still remain to be fully addressed and resolved. But, we have made progress. The agencies throughout the government have made progress. You mentioned a number of those areas where that progress has been made. Some of it is in the Department of Homeland Security, which we have jurisdiction over. We are pleased with that. Some is within the Department of Defense, and they have a lot more to do, but there is some good work that is being done.

But, if you think about the areas, where it is department-wide or with respect to specific parts of the departments' jurisdiction where actually real progress is being made, the real attention is being paid to the recommendations that they are receiving from you and, frankly, the hearings that we hold and the oversight that we conduct. What are the factors that better ensure progress? I like to say, find out what works, do more of that.

Mr. DODARO. Right.

Senator CARPER. What are the factors that appear again and again to be successful here?

Mr. DODARO. Yes. No. 1 is top leadership commitment. If you do not have the head of the agency or the deputy focused on this issue, you will make marginal progress, at best, in those areas. And, what I have seen, in Homeland Security, I have talked to Secretary Janet Napolitano, Secretary Jeh Johnson, the deputies, Jane Holl Lute, and Alejandro Mayorkas are focused on this, as well as the Under Secretaries for Management, just to give one example. The same thing at National Aeronautics and Space Administration (NASA). The deputy has been focused on this, Bob Lightfoot, and I know John Koskinen at IRS. So, the top people need to be focused. These are big, tough problems. They require prioritization in the agencies. They require changes in the culture of the agencies, and if they are not led from the top, they are not going to be successful.

Second thing is a good plan. A number of agencies start initiatives. There are no real performance measures or metrics in the initiatives. There is no way to hold people accountable for interim progress. The next thing you know, they are gone and there is a new political person that we are dealing with in the agency and we kind of start all over again. If there is a plan in place that has been followed, that is a good plan that has milestones and metrics that can transcend changes in political leadership in the Departments.

And, so, those two things are really very imperative, and the third thing would be engagement from the Congress. If it does not matter to the Congress and does not matter to the agencies appropriation and does not matter to its oversight, it is not going to matter to the agency. And, I can say all that I can say and encourage them, but Congress has to be a real partner in this effort to ensure success.

Senator CARPER. Thank you for all that. Let me just conclude, Mr. Chairman, on one last point.

I say to my colleagues, particularly those that are new, improper payments are a huge problem, and while they are being actually addressed, satisfactorily addressed in a number of areas, a big one that is still the elephant in the room is health care, Medicare especially, where the improper payments have gone up by about $15 billion, and Medicaid, which has ticked up by about another few billion dollars.

Dr. Coburn and I introduced in the last Congress something called the PRIME Act. It had over 25 cosponsors, and some of you on this Committee were cosponsors. We put it in the sustainable growth rate (SGR) fix, could not get it passed, but we are going to reintroduce it. My hope is that many Members of this Committee will be cosponsors of that legislation. We need to get it done. It will help ratchet down some of those improper payments, especially in Medicare and Medicaid, and we need to make progress.

Mr. DODARO. Senator, if I might add, one additional area that I think Congress needs to focus on is the Temporary Assistance for Needy Families program. Right now, the Department of Health and Human Services (HHS) does not believe it has the authority to collect information from the States to measure improper payments, so it is one large program where there is no measurement going on at all, and I think Congress needs to send a signal——

Senator CARPER. Good.

Mr. DODARO [continuing]. That needs to be taken care of.

Senator CARPER. Thank you. We will add that to our "to-do" list. Thank you. Thanks so much.

Chairman JOHNSON. Thanks, Senator Carper. I think you can rest assured that this Committee will be engaged, and the two of us working together, we will.

Before I call on Senator Lankford, you mentioned a 10-to-1 payback for the IRS. I did not mention in the Committee but I mentioned in the press conference, we often talk about cutting budgets and all we are really talking about is reducing the rate of growth in spending. Unfortunately, the GAO is one of these agencies where we have actually cut spending. We have gone from $556 million in 2010 to $480 million in 2013 and $522 million in 2014.

A quick back-of-the-envelope calculation in terms of payback, using your $40 billion figures, that is a 76-to-1 payback. Now, some of those may be one-time savings. But, if you add the $100 billion of Medicare and Medicaid and the other things you mentioned, that is a 268-to-1 payback. So, I would recommend that certainly all the Committee members be somewhat supportive of making sure that the GAO is fully funded because it is a pretty effective payback. Senator Lankford.

OPENING STATEMENT OF SENATOR LANKFORD

Senator LANKFORD. Comptroller Dodaro, thanks for being here, and thanks for all the work you and your whole team do to help keep us informed on some of these issues.

I want to mention one thing that has been on your list for quite a while and that is managing Federal real property. I was surprised, because I know there has been a big initiative to try to

lower the footprint of the Federal Government and the real property that are both owned and leased, the Freeze the Footprint Initiative that started several years ago to try to at least drop our hold to what we have.

I was a little surprised to see in your report that it listed that you all had done some studies on some of the Freeze the Footprint data and the drop, the 10 million square feet that we have actually reduced, when you actually studied and looked at it, you said it actually did not happen. They had either just moved to the General Services Administration (GSA) or it was just a timing issue. I wanted to give you a chance to talk about that a little bit, because this is a big issue that we have to resolve at some point. We have a lot of Federal real property out there.

Mr. DODARO. Yes. I am going to ask our expert in the area, Phil Herr, to come up and talk about it, but you are exactly right. I mean, what we found was that many of the initiatives that were underway before they started Freeze the Footprint activities, so they really were not attributable to the initiative.

A big problem in this area is lack of reliable data.

Senator LANKFORD. Right.

Mr. DODARO. That is one of the biggest problems. The government has a lot of underutilized or not utilized at all properties that need to be taken care of. There is an over-reliance on leasing in the Federal Government, where it may be more cost advantageous to have ownership over those areas over time. We have pointed out the program is not doing a very good job in securing the property, as well.

But, Phil can talk a little bit more about that particular study that you have talked about, but your characterization is accurate, for sure.

Mr. HERR. Yes. I would just add that it is a great example of the need for continuity and to followup. We know that OMB is working with GSA on a governmentwide strategy that is due in 2015. That is one we will be looking at closely. But, it is also really important, and I think it emphasizes the point that the Comptroller General just made, about just looking at the data and ensuring that there is integrity and looking and making sure those calculations are correct. When we did that, we found that there were some questions about double-counting, things being counted in multiple years, so—and that is a good example for the kind of oversight your Committee can do.

Senator LANKFORD. When we deal with actual disposal of property, obviously, we have all gone through for years the difficulty of actually disposing of real property that we own.

Mr. HERR. Correct.

Senator LANKFORD. So, have you all done any examinations for those independent disposal authority, those agencies that have that, their capacity to be able to dispose of property versus other agencies in the Federal Government, or when you deal with, for instance, the Department of Interior (DOI) and some of their authorities to be able to move out properties versus others?

Mr. HERR. We have not looked through that particular lens. The one thing we have looked at consistently are some of the barriers that agencies encounter in doing this. There is the processes—we

just did a report on the McKinney-Vento process and how that might be streamlined and how there could be better accountability, because that is something the property has to go through—agencies have to go through before proceeding with the disposal.

Senator LANKFORD. So, the Department of Interior that has the expedited conveyance process, where they can look at State and local governments, if this is going to be transitioned into other public uses, seems to be a faster process. Have you all had any opportunity to be able to examine that process and see if it is being effective——

Mr. HERR. Not in real depth, but that would be something we would be happy to work with the Committee on.

Senator LANKFORD. OK. that is one of the issues that I hope we can take a look at some point, to find out what is working, because it does not seem like every agency has this issue, but a lot of agencies do——

Mr. HERR. They do.

Senator LANKFORD [continuing]. To find out which agency is being effective at actually transitioning property that really works and what process is helping us in this.

I want to go back to some of our conversation on tax issues, as well, if I can jump back to that. The identity theft, you all brought up a very interesting set of statements there and I would like to go into a little greater depth on it, about the W–2 form and the time period of the W–2 form and how we have identity theft basically because the W–2 form does not come in late and we are doing returns early and there is a great opportunity for identity theft. How does that get resolved?

Mr. DODARO. Under the current approach, IRS starts processing returns early. They do not receive the W–2s from the employers until April. They go to SSA first. There is a different deadline in statute. So, we are recommending that the Congress should give IRS authority to require employees to file W–2s earlier. But, IRS really has not studied the costs and benefits of that. It may impose some burdens on the employers, and so we are recommending IRS study that. So, that is No. 1.

Senator LANKFORD. So, is it possible to just have that the returns cannot go out until the W–2s are in?

Mr. DODARO. Well, that is another possibility, but it will delay refunds, and, the——

Senator LANKFORD. People get pretty excited about that.

Mr. DODARO. Yes. Right. [Laughter.]

Particularly those that are expecting a big refund——

Senator LANKFORD. Sure, but we have also $5 billion of fraud that is sitting out there from identity theft——

Mr. DODARO. Right.

Senator LANKFORD [continuing]. And people are filing their taxes and finding out someone has already filed under that same number.

Mr. DODARO. Yes, and that is why we are asking IRS to study this thing, so Congress can make an informed decision. You might want to delay it a little bit and accelerate the reporting. I mean, there is a lot of room between the end of January, when employees receive their statements, and April. But, right now, the only way

they find out that there is fraud is when the honest taxpayer actually files their return and IRS says, whoops, we already paid the refund to somebody else who used your identity. And, the way people can get the information to file fraudulently now, either at the Federal or at the State level, is so easy to be able to do it.

The other thing that could be done is to give IRS math authority. In some cases, they know that a return is incorrect. They could fix it right away and not cause a problem over a period of time.

And, the third thing would be what we were talking about a little bit earlier, in having certification requirements and training requirements for paid preparers in a lot of cases. We know in some cases paid preparers are not giving the best advice to people. In the vast majority of cases, they do.

So, those three things, we think, can really help address this problem.

Senator LANKFORD. One quick transition, as well, and that is to the surface transportation. I know that you looked at some of the needs, obviously, that are sitting out there that are financial needs and that Congress needs to address. Have you had the opportunity to be able to look at the expansion of what is considered a Federal project over the last 20 years, just on the number of miles or roads or type of roads, because there has not only been an expansion of the need, but there has also been a tremendous expansion—my perception is—of the number of miles that are considered Federal project or the number of things that are considered Federal project in the last 20 years.

Mr. DODARO. Phil also happens to be our transportation expert so he is——

Mr. HERR. I will double-dip here. We have done some work related to that. I mean, one of the things that gets put into the Highway Trust Fund, you get a lot of the safety programs and things of that nature. Transit is also funded out of the Highway Trust Fund. So, you have a lot of things that have been put in there, a lot more demands, and the system is aging, so additional resources need to go into that to just help maintain those systems. And, the Interstate is now 50 years old, so rebuilding that is a big part of it.

Mr. DODARO. Yes, and our focus has been on the financing streams that go in there. Obviously, the Highway Trust Fund has not been able to meet the needs, and it is declining for a wide number of reasons.

Senator LANKFORD. Right.

And part of my question was just related to the actual roads themselves. I understand the safety and the transit and other things, but the actual number of roads that are considered Federal projects versus 20 years ago, the number of roads that were considered Federal projects.

Mr. HERR. Well, they worked to bring in the National Highway System, so that would be one area where you Federalized some of those. But, we can get back to you with additional data on that.

Senator LANKFORD. Thank you. I yield back.

Chairman JOHNSON. A real quick question. Is not the W–2 a multiple-part form? Would not a pretty simple solution be to add another copy?

Mr. DODARO. I will talk to our experts about it and see what——
Chairman JOHNSON. Senator McCaskill.

OPENING STATEMEN TO SENATOR MCCASKILL

Senator MCCASKILL. Yes. I was going to say the same thing. If the employee gets it in January, or early, that means the employer has it, so it is not like we are asking the employer to produce something earlier, because it has already been produced. We are just asking employers to get it in the hands of the IRS earlier. So, I do not know that asking the IRS to study this is a good idea—because I know what that "study" word means. It means we are going to be at this for much longer than we should be at it. So, Mr. Chairman, I would like to——

Chairman JOHNSON. We will cosponsor a bill.

Senator MCCASKILL [continuing]. See if we cannot, with the protection of the Chairman, who would stand for the proposition that we are not trying to burden businesses, maybe we can get through this.

Chairman JOHNSON. They should not be a burden.

Senator MCCASKILL. There we go.

Our Subcommittee last year held hearings, as you know. First of all, good to see all of you. Your stuff is required reading in my shop. Someone asked me about how depressing it must be to be in the minority, and I said, one thing about oversight, a GAO report is the same when you are a Democrat in the majority and the same when you are a Democrat in the minority. Thank you for all of your work and please share that with all of your colleagues at the mother ship. [Laughter.]

We held a hearing last year, in the last Congress, about the overpayments in medical equipment, as you know. I want to make sure everybody understands how bad this is. In 2012, according to the data provided by the Centers for Medicare and Medicaid Services, they made improper payments on medical equipment of almost $6 billion. So, that means there is $6 billion worth of pure waste, overpayments being made, on durable medical equipment. And, that is an error rate—just so people have a concept of how bad it is—of 66 percent. They recover hardly any of these payments. I think in the last data we had available, CMS recovered only $34 million of an estimated $5.2 billion in improper payments.

We learned in that hearing that they do not do anything up front to screen. They keep sending to one address, thousands of businesses registered at one address, until after the fact, then clawing back and they are gone. They are indicted. In fact, one of the companies was at that hearing. As you recall, I was very suspicious about their name. Their name was Med-slash-Care. They were calling seniors and saying, "This is Medicare." And you can get this and you need this. They were sent all this stuff out and they were criminally raided by the FBI a few weeks ago.

So, your recommendations to CMS have not been followed. What is your sense as to what is the problem at CMS that they will not accept and adopt the recommendations in this incredibly low-hanging fruit where we could save a lot of money?

Mr. DODARO. Yes. Cindy Bascetta is our expert in that health care area. I will give my take and I ask her to provide more detail.

First of all, part of this is changing this culture that had been ingrained in CMS for years. It was to pay fast and get the money in the hands of the providers to make sure there was nobody who needed care that was not receiving care, and so that culture is really ingrained in the process over a period of time.

And, they have established a Payment Integrity Center, but they are slow to implement these recommendations. You have to keep bad actors out of the system. One of the things was to establish a surety bond up front so that there is money that the contractors have put up. They finally now have gotten to where they have a contractor that can do fingerprint and background checks ahead of time, so they are going to put that in place.

So, the first thing is to stop bad actors from getting into the system to be providers, and that has been difficult for them to grapple with, and they are starting to move slowly in that area.

The other thing is they give an incredible amount of discretion to the contractors who are making these payments in error. You would think Medicare was one system, but it really is not. There is a lot of discretion given to the contractors. We have been trying to say, get the contractors to identify their best practices for preventing payments and recovering the funds and to share that with all the contractors so that there can be best practices. That has not been implemented. We have encouraged them to set up core compliance programs that providers have to follow. That has not been implemented yet.

I have tried to raise this as an issue. I have met with Secretary Sylvia Mathews Burwell and the former head of CMS, Ms. Tavenner, and I emphasized these open recommendations we had and the need to implement the changes. So, I have certainly been doing everything I can. I think additional congressional oversight would be really helpful in this area, and I will let Cindy give anymore details.

Ms. BASCETTA. I would just add that we have also encouraged them very strongly to move more quickly on their predictive analytics, which would really help prevent the overpayments in the first place and identify bad actors rather than recoup payments. With respect to durable medical equipment (DME), I just point out that their competitive bidding program that was instituted several years ago——

Senator MCCASKILL. It is working.

Ms. BASCETTA [continuing]. Has, indeed——

Mr. DODARO. Yes.

Ms. BASCETTA [continuing]. Yielded many savings. We are watching carefully to make sure that they do not get to the point where there might be negative effects on beneficiary access to the equipment that they need. But, they are making progress in that area.

Mr. DODARO. But, you are right. The problem is bad.

Senator MCCASKILL. It is bad.

Mr. DODARO. And it is going to get worse, because of the fast——

Senator MCCASKILL. It is going to get worse, and there are things that can be done to fix it.

Mr. DODARO. Right.

Senator MCCASKILL. So, I know Chairman Susan Collins—she and I are serving on the Aging Committee now—I know we are

going to continue this investigation, and continue to put pressure on CMS.

In the comprehensive immigration reform bill that was passed by a wide bipartisan margin in the Senate, we funded an additional $46 billion in border security. I am confident, no matter how the immigration politics play out over the coming months in this Congress, that all of us agree that there has to be additional significant funding on the border. I am worried about whether or not DHS management is ready to absorb this flood of funding. I am trying to remember—53 miles of the border, I think, we did for a billion dollars. That is not exactly encouraging, that it took us a billion dollars to do 53 miles.

I would like, just briefly, if somebody could speak to that, and, frankly, if you have an opinion, I think the Chairman is a former businessman and I know if he did not know if his receivables, if and when they were ever going to arrive, it would be very hard to manage an ongoing enterprise? And whether or not the fact that we are budgeting by crisis in fits and starts and continuing resolutions (CRs) and threatening shutdown, if that is contributing to some of the mismanagement at DHS.

Mr. DODARO. Well, I can just speak from trying to run the GAO under continuing resolutions; it is a difficult process. I told our appropriators one of the things I never aspired to be in public service was an expert at managing under continuing resolutions. It does create a lot of uncertainty and make it difficult to manage.

Dave Maurer is here. He is in charge of our work at DHS. I do think they are still struggling in the acquisition area to properly manage their acquisitions. That is something we are keeping an eye on and we will focus on this additional funding. Dave.

Mr. MAURER. That is absolutely right. Acquisition is one of the major challenges DHS faces on the management front. They also face some significant challenges in other aspects, as well. Employee morale, for example, at DHS has consistently been bottom-of-the-barrel compared to other departments. Their numbers have been going down at a faster rate than in other Federal agencies. That is something of concern. We are encouraged by the fact that the Secretary and the Deputy Secretary have taken some efforts to address both of those issues head on—both acquisitions and morale. It is something we are going to be watching very carefully in the coming years and months.

Senator MCCASKILL. Thank you, Mr. Chairman.

Chairman JOHNSON. Real quick, to answer your question of the Chair, it is our side of the aisle that is actually trying to get a bill on the floor to be debated to fund the Department, so——

Senator MCCASKILL. Well, we would disagree on that.

Chairman JOHNSON. I think, also, Senator Baldwin and I will also agree that I think our paper industry would kind of like our W–2 fix, so we will work on that.

Senator MCCASKILL. That is right.

Chairman JOHNSON. Senator Baldwin.

OPENING STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman, and Mr. Dodaro, thank you for being with us today.

I would like to focus in on the problems that you have identified in the GAO report with the Veterans Health Administration (VHA), both systemwide but also in Wisconsin and facility-based issues. The GAO report provides ample evidence to corroborate what I have learned in disturbing detail over recent weeks, that the VHA suffers from mismanagement and inadequate oversight, especially of individual facilities. It appears that the Veterans Health Administration lacks not only clear and appropriate systemwide policies and protocols, but also lacks the ability to ensure that they are followed at the facility and the regional Veterans Integrated Service Networks (VISN) level.

For example, at the Tomah VA facility in Wisconsin, current and former employees and veteran patients have brought to my attention allegations of inappropriate opioid prescription practices and abuse of administrative authority, including retaliation against whistleblowers. This facility is currently under investigation by Secretary McDonald and we all hope that it yields appropriate and positive results. But, make no mistake, extremely troubling issues have come to light regarding the VA and this specific facility, and I believe that Congress is going to have to act in a variety of ways to make improvements so that our veterans in Wisconsin receive the care that they deserve.

Mr. Dodaro, in the case of the Tomah VA facility, a report initiated in 2011 and concluded in March 2014 from the VA Office of Inspector General found evidence of troubling opioid prescription practices that were at considerable variance from peer facilities in the regional network. This report recommended changes to address those problems at the facility level, and subsequently, actions were taken.

In the last month, however, media reports have revealed that whatever those actions were that took place to remedy the problems had either not been implemented, not been implemented effectively, or were entirely insufficient. It is also unclear if any senior VA official ever was made aware of the report that the Inspector General did or the remedial actions that were recommended or taken at the Tomah VA.

In your view, does the Veterans Health Administration have adequate oversight controls in place to ensure that facility-level problems are first, identified, and then sufficiently addressed?

Mr. DODARO. I will ask Debbie Draper to elaborate on this. She is our expert in the VA area.

But, one of the areas we point out in the report we are releasing today is there really is inadequate oversight and accountability. The individual facilities have been given wide latitude to implement the policies and procedures. There are not reviews being done by headquarters that should be done of the facilities to make sure that they are adequately following the policies and procedures. And, when we go in, we find that those reviews are not done. They are relying on self-reported data from the facilities, which is not consistent with proper internal controls, and to have a good accountability and evaluation of function and program. So, it is a real

problem over there that needs attention, but I will ask Debbie to elaborate.

Ms. DRAPER. I mean, it is certainly a system that is in need of major transformation, and I think that we have seen—and one of the reasons we have added it to the High-Risk List is that over and over in the past 5 years, the reports that we have issued have constantly highlighted the inadequate oversight and accountability and ambiguous policies and inconsistent processes. So, there is an aversion to standardization within the VA, but when you have that much autonomy at the local level, you often hear the story, you have seen one VA medical center, you have seen one VA medical center, and that is really true, because there are, like, 150 different processes that play out at the local level.

We are particularly concerned because of the growing demands on the VA Health Care System. So, between 2002 and 2013, the number of veterans enrolled in VA health care increased from 6.8 million to 8.9 million, and over that same period of time, the number of outpatient medical appointments increased by 40 million. So, if you have weaknesses in place and you do not correct them, then the problems are going to really become much bigger.

Senator BALDWIN. Mr. Chairman, I have a second question on Tomah, but I believe I am not going to have time to get to a third question on a GAO report that was issued in November 2014 regarding protocols with treatment of veterans with major depressive disorder. I would like to be able to submit that remaining question for the record and get a response after the fact.

But, to my next question in the case of Tomah, there seemed to be virtually no internal Veterans Administration communication and certainly no external communication to Congress or the public regarding the problems at this facility. In fact, when I first contacted the Tomah facility and the VA headquarters here in Washington on behalf of a constituent who had raised a number of concerns covered in the Office of Inspector General (OIG) report that I just referred to, no one at any level of the VA talked about the existence of this report or informed me of the existence of this report.

And, in light of this lack of transparency, I wonder if you think that a GAO-type model of investigating, issuing recommendations, and requiring the affected agency or group to formally and publicly respond would improve the Veterans Health Administration's ability to perform successful oversight at the regional and individual facility level and hold them accountable for any wrongdoing uncovered.

Mr. DODARO. Well, there definitely needs to be accountability over reacting to audit findings. In fact, there is existing OMB guidance that agencies are supposed to track audit reports and track followup efforts and have a response. I met with Secretary McDonald last Friday, actually, and he said he has given high priority to begin following up on IG recommendations and GAO recommendations. So, hopefully, this will be addressed.

But, you are exactly right. There are policies and procedures already in place that should have assured that they followed up on every IG report and recommendation that would be in place, and GAO reports, as well. Those could be strengthened, and there may

be a need to do that in this particular case. But, those policies exist. So, it is a lack of compliance with existing policies that it sounds like. I mean, we have not looked at this specific information, so I really do not know for sure, but it sounds like from your description that they just did not adhere to the policies that already exist.

Senator BALDWIN. Thank you, and I will submit for the record the GAO report[1] that was issued in November 2014 regarding veterans who are diagnosed with major depressive disorder. It appears that there is a huge deviation from VA guidelines with regard to the treatment that you have uncovered and I think that is very disturbing and that we need to do more in followup to that, too.

Mr. DODARO. And we will be happy to respond.

Chairman JOHNSON. Thank you, Senator Baldwin. I can assure everyone, this Committee will be fully engaged to make sure these recommendations are carried out, and we are going to do everything we can to make sure they are carried out. Senator Heitkamp.

OPENING STATEMENT OF SENATOR HEITKAMP

Senator HEITKAMP. Thank you, Mr. Chairman.

I want to get to process, because if we were going to go through each one of these and debate their relative merits, Comptroller, we would be here all day. And, so, I want to talk about why we have these hearings and then everybody retreats, goes back to their agency, goes back to what we do, and then we come a year later and have another discussion.

So, I want to ask about ongoing supervision and get to the heart of what you were talking about earlier, which is agency heads change, administrators change, and then you are back in the game again trying to educate or re-educate on why these recommendations were necessary. Let us just presuppose that every time something like this was done, we had a sit-down, we had a strategic plan put together, time-lined, with accountability measures that everybody agreed to and said, "Yes, we are going to do it," taking a look at—I think earlier, Senator McCaskill talked about return on investment, low-hanging fruit, prioritizing those things that actually give us the biggest bang for the buck, and then periodically actually getting reports on whether we are meeting those requirements so that this process becomes institutionalized between the Congress and the agencies and GAO.

Mr. DODARO. I think that would be an excellent idea and I would be happy to participate.

Senator HEITKAMP. I think it would be an excellent idea, but I have a tendency to fall in love with my ideas, so I just need——
[Laughter.]

I need people to argue against me frequently, but——

Mr. DODARO. Well, I will not argue on this one.

Senator HEITKAMP. I think that is the level of frustration that we all have here, which is——

Mr. DODARO. Well, and I have the same frustration. I try to do what I can, working with the agencies and the Congress, but we need more concentrated focus on this. I mean, our government's fi-

[1] The GAO report submitted by Senator Baldwin appears in the Appendix on page 78.

nancial condition is not sustainable over a long period of time and we are wasting too much money on these inadequate processes and procedures. So, whatever process that you can convince your colleagues to do, I will participate in.

Senator HEITKAMP. Well, it does seem to me that that would be a critical kind of component of followup, because the great work that you do and actually going out there and identifying these problems, identifying the areas of concern, if we do not have a systematic process piece to go behind it, we really are only talking to each other——

Mr. DODARO. Right.

Senator HEITKAMP [continuing]. And wringing our hands and decrying the waste of Federal dollars instead of actually fixing the problem.

Mr. DODARO. Yes. A good model is what we have been doing with DHS, for example. When I first met with them, the Deputy Secretary, they said they really did not know what to do to get off the High-Risk List, so I sent them a 29-page letter and specified all the things that they needed to do to get off the list. [Laughter.]

But, to their credit, they said, "OK, we understand now. We agree." They put a corrective action plan together. That plan has withstood changes in political leadership over at DHS. I meet with the current Deputy and they are making good, steady progress to that area. We have informed the Congress of these matters and Congress has given some attention. So, most of this stuff, except maybe for NASA, it is not rocket science, but—— [Laughter.]

And it just requires disciplined follow-up.

Senator HEITKAMP. Well, and it requires some continual oversight that is not sporadic——

Mr. DODARO. Right.

Senator HEITKAMP [continuing]. That is meaningful. And, I think that is to the extent that you guys need us to play bad cop, we are way willing to do that. So, we will work on a discussion, I think, going back and forth on what that process could be.

I want to just, in the time that I have left, talk about the IRS and talk about what seems to be a systemic failure to institutionalize processes that would prevent fraud. And, I want to start out by saying, obviously, if someone has a W–2 in their hand, there is a W–4 somewhere that has been filed with someone relaying this information. But, this information, according to Social Security dollar amounts, is relayed every time there is a payroll, is it not?

Mr. DODARO. I am not sure. Jim, do you know? This is Jim White, who is our tax expert.

Mr. WHITE. Some come in throughout the year, but the information that IRS needs to match, they do not have all of that information until after April 15 for the prior year——

Senator HEITKAMP. But Social Security has it.

Mr. WHITE. Social Security——

Senator HEITKAMP. When is the W–4 due to Social Security?

Mr. WHITE. It depends on whether it is paper or electronic, but it is due either February or March——

Senator HEITKAMP. Give me the date, though.

Mr. WHITE. Well, some of them are due at the end of February. Some are due at the end of March.

Senator HEITKAMP. So, the employer can have prepared W–2s, but transmittal of those W–2s to Social Security does not occur until the end of February?

Mr. WHITE. Correct. And, part of the reason for that is there does need to be a window in there for employers to correct errors, so they give it to the employee. Sometimes the employees go back. There are errors there that need to be corrected. Social Security also has an error correction process. And then those go to IRS.

The other problem is IRS does not have the information systems, the computer systems that would allow them to do real-time matching. So, that would be another part of this. If the forms came in earlier, IRS would need improved computer systems to be able to match real time to taxpayers' tax returns.

Senator HEITKAMP. It is really hard for those of us who deal with the complexities of Amazon.com to really believe that in this day and age, they do not have real time matching capability. And, so, that is something, obviously, that needs to be funded if we are going to be serious about fraud detection.

I want to get to the identity theft, because none of this would really solve the problem of someone seizing that Social Security number, filing a fraudulent return, and what would be a way that we could prevent that if, in fact, the real taxpayer does not file until April 15?

Mr. WHITE. Well, you are right. The crooks file early. They need to beat the honest taxpayers' tax returns. So, they file early. When the honest taxpayer files, IRS at that point discovers they have duplicate returns and they know they have a problem. But, they do not find out until after they have issued the refund to the crook, and at that point, then they are trying to chase the money.

Senator HEITKAMP. Yes.

Mr. WHITE. So, the solutions—the pre-refund matching, getting the W–2s in in time to match to taxpayers' tax returns before refunds are issued, would put a big dent in the fraud. It is not the only solution.

Another solution——

Senator HEITKAMP. That, I do not understand, and I am obviously out of time, but if somebody is going to seize that Social Security number and file a fraudulent return, you need to know that that is a fraudulent return if you are simply matching it against—are you suggesting that because the dollar amounts would vary, that would——

Mr. WHITE. Right.

Mr. DODARO. Yes. The person perpetrating the fraud really does not know what is in the other person's W–2——

They are just making up the numbers. The other thing that is related to this is another recommendation we have. For 54 million Americans that are enrolled in Medicare, their Social Security number is right on their Medicare card, and we have——

Senator HEITKAMP. Yes. Not good.

Mr. DODARO. Not good.

Senator HEITKAMP. Mr. Chairman, if I can just ask one more question, if we take and actually use old data—by that, I mean old numbers, this is your employer on that Social Security number, and use the previous tax year, you might actually get at least a

bank of those returns that would be incorrect or would not match unless that taxpayer changed their status or changed their address or changed their job. Would that not be a screening technique we could use?

Mr. WHITE. It is a possible screening technique. The tradeoff there is, given the number of Americans that change jobs, change home addresses each year, IRS would have millions of false positives with that kind of match so they really need current information.

Senator HEITKAMP. I agree, but what I am saying is at least then you might be down to 20 percent of those returns that you do not know. I mean, I do not think more than 20 percent change jobs or change addresses every year.

Mr. WHITE. Yes, and IRS has made real progress with their filter system, so they have caught—they have prevented $24 billion worth of fraud because of filters that do some of what you are talking about right now. The problem is the $6 billion—it is the $5.8 billion of fraud that is still getting out the door.

Senator HEITKAMP. Thank you, Mr. Chairman.

Chairman JOHNSON. Senator Peters.

OPENING STATEMENT OF SENATOR PETERS

Senator PETERS. Thank you, Mr. Chairman.

Mr. Dodaro, thank you for your testimony, and for appearing before this Committee this morning. I certainly appreciate all the work that you have done with your agency in developing a High-Risk List that we are discussing today. We are looking for common ground in Congress. I think we all can agree that trying to eliminate fraud, waste, and abuse, mismanagement, those are things we should all be able to agree on, focus on, and work to achieve.

But, as you know, in many cases, there is only so much that a Federal agency can do to deal with some of these issues without legislation and congressional action, and the GAO has identified a substantial number of High-Risk List areas that will many times require some sort of legislative action in order to be addressed.

Last Congress, when I was in the House, I introduced with my colleague Cory Gardner, who is now a Senator with me here, legislation that would have modified some of the House rules, put a process in place to require Committees to hold hearings on programs, agencies, offices, and initiatives with duplicative goals identified by your annual GAO report, which I always find a fascinating report. One example I often give, particularly in my district, is the example where you have multiple folks that inspect catfish in this country.

Now, I would think we should at least have one government agency that regulates catfish. I would agree with that. I like to know when I am eating catfish that it is safe and it has been raised properly. But, whether or not we need more than one does not make a whole lot of sense to me, and oftentimes it is Congress, because of different jurisdictions that we have with our Committees, that we like to hold on to those jurisdictions, it is Congress is the problem here, not just the agencies, as to why we have to have that duplication, and I certainly think that we can do better.

In the House, I also introduced with another one of my colleagues now, Senator Lankford, who is actually on the Committee with me here, a followup to a report that I requested from the GAO. I appreciate the reports that I get from you. Your report studied the use of remanufactured auto parts in the Federal vehicle fleet and found that these parts can reduce operation and maintenance costs, sometimes significantly. To ensure that the findings of this report are available and considered by all Federal fleet managers, together, we introduced the Federal Vehicle Repair Cost Savings Act to encourage all Federal agencies to consider remanufactured vehicle parts, and we are going to continue to work on that in this Congress.

However, the reason I bring this up is I am concerned that too many of your GAO recommendations—I have heard that from some of the other questions here—are never implemented and Congress never follows up on these recommendations. It is Congress, the folks right here in this room and other places, that never followup on these.

So, I am going to ask you to be candid. I am going to ask you to give us a critique of Congress. In your experience, how effective has this body been in actually responding to the incredible work that the GAO does? And, again, please be candid, and we will not hold it against you. I certainly will not. I know the Chairman will not, either.

Mr. DODARO. Well, that is good to know. [Laughter.]

In the overlap and duplication work that we do and issue our annual report, we actually have a separate scorecard for the Congress and a separate scorecard for the Executive Branch in terms of responding to the recommendations. And, we found that the Congress was responding to the recommendations a tad less, the rate—but still responding—than the Executive Branch activity. So, on a comparative basis, the Congress's record was relatively less favorable to the Executive Branch, if my memory is correct. I will go back and I will give the exact numbers for the record.

Our next report will be out this April. It will be our Fifth Annual Report. So far, we have made 440 specific recommendations for change in those areas. But, there is much more that Congress could and should do.

Last time we updated the High-Risk List, I was before this Committee and I raised the issue of the need for legislation on the Postal Service. Their business model is broken. They are losing billions of dollars. One of the first hearings the Committee held was on the Postal Service. I testified at that hearing. The next one was on cybersecurity, and eventually, there were bills passed on cybersecurity. So, there is a lot more that the Congress needs to do in order to rectify these High-Risk Areas and address the overlap and duplication problems.

If legislation is introduced again along the lines of what you talk about, that require hearings in the overlap and duplication area, my suggestion would be that it also require joint hearings of different Committees, because, really, the most difficult problems are because of jurisdictional issues in the Congress.

But, that is not the only problem. The problem is in the Executive Branch, too. I mean, they are compartmentalized the same

way that the Committees are compartmentalized in terms of jurisdiction, and I have difficulty getting OMB's attention to—and prioritize, because they only have limited resources—to get the agencies to work together or to say, these things ought to be combined into one function. So, that problem exists in the Executive Branch and the Congress, which compounds the difficulty in getting solutions to those areas.

That is about as candid as I could be——

Senator PETERS. Well, we appreciate that.

Mr. DODARO [continuing]. At this point, and thank you for the question.

Senator PETERS. Well, I appreciate that, and what I am hearing from your answer, and obviously, there are problems in both the Executive and Legislative, but as you are saying, with the scorecard, we actually in Congress perform less than the agencies, which is not a good standard for us. We think the agencies should be doing a lot more, and if we are behind them, that just shows that we have more work to do, and particularly when you are as—which is a great suggestion about having the joint hearings to deal with some of the turf battles that are there.

But, I think you would agree, then, that if we introduce bills like I have introduced with some of my colleagues here in the House and do that here, and putting in place a more formal process that forces Congress to deal with this in a formalized way, you think that is a good idea? You would support it and encourage it?

Mr. DODARO. Yes. And, I would participate.

Senator PETERS. Right.

Mr. DODARO. I would be here any day to testify.

Senator PETERS. Great. And be equally as candid.

Mr. DODARO. Yes.

Senator PETERS. Thank you, sir.

Mr. DODARO. Sure.

Chairman JOHNSON. Senator Peters, coming from a manufacturing background, I certainly understand, without a good process, you do not have a good product. So, I appreciate your enthusiasm. I see you are on the Subcommittee under the Government Affairs part of this. We will stay engaged. I am looking for low-hanging fruit. When we are passing through the Senate, we need six Democrats joining us. We have seven on this Committee. That is an aspirational goal. Let us find those areas, and certainly the biggest bang for the buck, but also just those areas of agreement. So, we are committed to doing that and appreciate your engagement on the issue. Senator Ayotte.

OPENING STATEMENT OF SENATOR AYOTTE

Senator AYOTTE. Well, thank you for your important work. We appreciate it. And, I think Ronald Reagan once said, there is nothing closer to eternal life than a government program. [Laughter.]

So, one of the things is to followup on Senator Peters' comments, is I am not surprised that we have a low score in terms of when it comes to duplication and overlap. In fact, Senator Manchin and I have a bill—it is called the Duplication Elimination Act—and I hope the Chair might consider taking a look at that bill. Because

this issue, as you have identified, is a problem on both ends. It is the Executive Branch and it is the Congress.

And, so, this bill would actually require the President to submit to Congress a joint resolution to implement or reject GAO recommendations when they are made. And, if they are rejected, let us know why. If they are accepted, let us know why and how we plan to do it. And then it would require us in Congress to actually undertake an expedited review of those and to vote on them so that we could adopt things more quickly, because you do excellent work. GAO does excellent work and it sits on the shelf too often. The last thing we want is to continue funding programs that are not effective where we have places we need resources and it is a better allocation of resources.

So, I am hoping that might be a bill we might consider making, but, basically, we all need a kick in the pants on this, and with your help, I hope we can do that, because what ends up happening, and I do not need to tell anyone here what happens. I have done it. Offer an amendment on eliminating or reforming one program on the Senate floor in an appropriations bill, and every program has a constituency. So, even if it is underperforming for almost every constituent it serves, that one constituency comes to their Senator and argues for it and here we are and nothing gets done.

Well, we need to look at the big picture here, and I know that you are doing that and that is important, and so I am glad to hear Senator Peters focus on this, because this is a bipartisan issue. It is really—the Chairman, as well. And, I thank you because the work you are doing is excellent.

I wanted to followup on the VA issue, because for New Hampshire, on the Choice Card issue, we are getting, as a State that is one of the States that does not have a full-service Veterans Hospital, the Choice issue in the veterans bill is very important to my State. So, what I am hearing from people in New Hampshire is that the third—the Choice Card is being processed through a third-party contracting agency and that we have veterans calling the office essentially saying that there is not enough information being given to veterans, that veterans are saying that they want to—if a veteran comes to you and says, "I want to see a particular doctor," that might allow them to go and connect the veteran with the doctor. It may or may not. That has been complicated on that end. But, also, that if the veteran just says, "I need this service," they are sort of left hanging.

And, one, I wanted to get your thoughts are, is one of the things that was identified on the veterans' end in the report that you issued is the provision of non-VA care. So, in a State like mine, it is really important, because we do not have a full-service Veterans Hospital. It is addressed in the bill. So, we are giving our veterans access to more non-VA care. Are you going to do further work on this non-VA care issue, because Congress clearly shifted and expressed a preference to introduce more opportunities for our veterans in it. It seems to me, though, that the Veterans Administration has been really resistant to reform. And, we talk about access in veterans facilities, but they seem somewhat resistant in terms of informing veterans on what their rights are on the non-VA care.

And, so, I wanted to get your thoughts on what further work we think we need to do on this provision of non-VA care. How do we get this, the Veterans Administration, to stop being so resistant to reform, because Congress has clearly expressed on a bipartisan basis it is about the veteran and we want to make sure that we get them proper care.

Mr. DODARO. Yes. Well, I would just say that we will do the work necessary in the future to make sure that this issue gets resolved satisfactorily. Debbie Draper is our expert in this area. I would like her to speak to the issues that need to be resolved. But, in putting this area on the High-Risk List, a couple areas I was really troubled by. One was the fact that VA does not followup to make sure if there is a referral that it actually happens, and they do not have good information to know whether it is more economical——

Senator AYOTTE. Right.

Mr. DODARO [continuing]. To give VA care or non-VA care.

Senator AYOTTE. So, what makes me worried about all this is I hear it, because for New Hampshire, really important, and the issue is this, is that if the VA almost wants to—I mean, I do not want them to want to undermine the access to non-VA care, because if we have good data, we may find down the line that this is actually a better way to serve veterans, to avoid wait lists, and the cost efficiencies may be there. But, if they do not follow through on this, it is almost a self-perpetuating failure——

Mr. DODARO. Yes.

Senator AYOTTE [continuing]. Which is contrary to what Congress wanted to happen in the reform bill. So, I appreciate your being here.

Ms. DRAPER. Yes, we have several concerns. I mean, before the Act was passed, we had done prior work looking at non-VA care and we found that the payment to providers was slow or often inaccurate and community providers were really unwilling to take some of the VA patients.

But, beyond that, it was intended to improve access to health care, the timeliness of care. However, there was no infrastructure in place to really monitor wait times, how long people are actually waiting to get into those community providers. So, we do have a number of concerns and that is one of the reasons that we put VA health care on the High-Risk List.

Many people see this as a panacea for some of the access problems. I think there is a lot of work that needs to be done to make sure that the infrastructure is in place, to make sure that people are actually getting timely care through that system. And, I think another important point is the VA Health Care System is a difficult system to navigate. So, now you are introducing a second system for someone to navigate. So, it just compounds the problems that exist or could exist.

So, we do have a number of mandates under that Act to really look at the issue. So, we will be doing that over the next couple of years, looking at the non-VA care.

Senator AYOTTE. I think it is really important, and I hope that you also look at, as you look at this, how embracing has the VA been of access to non-VA care, because, again, I worry that if the VA does not embrace giving veterans access to non-VA care, then

you can basically ensure that it really does not give veterans that option and it really becomes self-perpetuating in terms of the conclusions that can be drawn from it.

And, for veterans in New Hampshire, for example, they were on buses being shipped to Massachusetts and other places. If they can go to a local provider in their community, which, obviously, people have been able to do through other Federal programs, then that, in the end, if you look at the cost efficiencies of not paying for the transportation, of access to care in terms of quality—now, not everything is going to fit in that category, but a lot of care can.

So, I am hopeful, in the long term, that we are not just allowing the VA to want to perpetuate their own system, but we really do look at what is best for the veterans. So, I know that you can be a very important voice on this. Thank you.

Ms. DRAPER. And, just one other thing. I think we have seen a lot of variation, as we do with most other things related to VA, about how each facility is handling the non-VA care. And, so, that is something that, again, there are not standardized processes, and they also rolled out this program very quickly, so over a couple months, Choice Cards were mailed to veterans——

Senator AYOTTE. Yes, and they were not told anything about them and they were, like, all contacting our office. So, information, I think, is important, as well.

I know I have gone over my time. I have a couple of additional questions that relate to the IRS and also the Earned Income Tax Credit (EITC) and Additional Child Tax Credit (ACTC) tax payments that I will submit for the record. I appreciate all that you do. Thank you.

Chairman JOHNSON. Thank you, Senator Ayotte.

I think you can tell by the number of questions, by the depth of the concern, how much, first of all, we appreciate the fact that you are highlighting the problems in the VA, and so you can, again, rest assured, you will have support and we will continue to be fully engaged, which is certainly what you mentioned in terms of the process to make sure these reforms are implemented across your High-Risk List.

You will have full engagement by this Committee on all the items, but in particular, that you can rest assured that the VA system is going to be a top priority of this Committee.

Just real quick, I do want to followup on IT acquisition. I have been meeting with the different agency heads within DHS and I am pleasantly surprised by the repeated, I guess, assurance that they are starting to look more at off-the-shelf solutions as opposed to having the government specify something and have through government contract, trying to have some IT solution created specifically for the government, which is not particularly efficient. Are you finding that not only within DHS, but is that a reoccurring theme? Is that something you support, or are there any dangers to that?

Mr. DODARO. Well, we have long said that commercial solutions, and even if you have to change your business process a bit, are more efficient than customized software development. So, that has been something we have been emphasizing over time to agencies.

Dave Powner is our expert in the IT area and he has a good vantage point, across government, so I will ask him to elaborate on that.

Mr. POWNER. Yes, Senator Johnson. If you look at commercial solutions, that actually is one area you should look at instead of building. That is buy. There are a couple of things in our High-Risk Area that endorse that. If you look at incremental development, if we go with smaller, quicker deliveries, commercial solutions will be considered more heavily.

The other area is cloud computing. We need to look more at cloud solutions and have providers actually provide those services to agencies instead of always building them and go more to the cloud. So, I think with commercial, both incremental and the cloud solutions, which is emphasized in our High-Risk Area, will be quite helpful.

Chairman JOHNSON. Well, thank you. Again, I am really encouraging that. Coming from the private sector, I never liked reinventing the wheel, so it just makes perfect sense.

Before we conclude the hearing, I do also want to just touch a little bit on cybersecurity. Our first hearing was on cybersecurity. That is a top priority of this Committee, is that first step. Can you just speak to the privacy that Americans are going to lose if we do not address this problem? Again, part of the reason we have not been able to pass cybersecurity legislation is because we have not been able to provide the liability protection to facilitate the needed exchange of information within the private sector, the private sector to the government, and back down.

And, again, there are legitimate concerns of privacy. But, one of the points I tried to make in the hearing and I think we need to underscore, and I just want to get your comment on it, if we do not take that first step, if we do not allow that information sharing, which does allow us to share that threat signature which can prevent attacks—it is not a panacea. It is not going to protect everything. But, the more attacks we can prevent, we are protecting Americans' privacy. Can you just comment on that?

Mr. DODARO. First of all, I think people need to understand that the amount of information that is collected, disseminated, and stored in the Internet by most projections is expected to double and triple every 2 years going forward. So, you have a tremendous amount of information available now, but the storage capacity is—such that so much more information is going to be collected and it is going to be shared and disseminated, including personally identifiable information, over time.

The only way to deal with this, and we have been advocating sharing, partnerships with public-private sector for many years now, since we have been focused on this area, and people have to understand that the best safeguard is continuous monitoring and diagnostics and preventing these events from occurring.

Greg Wilshusen is our expert in this area. I will ask him to elaborate on it. But, we will do whatever we can to help people understand that information, more information is going to be available. The question is how best to protect that from getting into unauthorized hands and information sharing is a critical component of that protection.

Chairman JOHNSON. I would also, quickly, like to point out that every time you agree to the privacy statement of an application, you are giving up so much information that is widely disseminated in the private sector, and so people need to also understand that. Sir.

Mr. WILSHUSEN. Yes. And, I would just like to say, too, that the need for sharing information, particularly about actionable cyberthreat information and incident information, is really critical to help better protect our critical infrastructures.

A couple years ago, we did a report which identified among our private sector partners that they said that their expectations of the public-private partnership for protecting critical infrastructure, that 98 percent of them indicated that receiving actionable cyberthreat information and incident information from the Federal Government was of a great need for them. However, only 27 percent of the respondents to our survey, who were the critical infrastructure owners and operators, said that they were actually receiving that type of information to a satisfactory degree from the Federal partners. So, it is critical that the information sharing processes be improved.

Chairman JOHNSON. One of the hangups always has been that liability protection, and I am not the person to say exactly what that liability protection ought to be, but I can say that the metric is going to be if we pass something with liability protection, the success or failure is whether or not that information actually is shared. I mean, can you speak a little bit in terms of the reluctance of private sector companies to share the information the threats they really do feel in terms of lawsuits if they share that information, and the reluctance, as a result, to share it without really strong liability protection.

Mr. WILSHUSEN. Well, certainly, I think, liability protection is one of the areas that is an inhibitor to some of the private sector companies. Our reviews have also shown is that often when private sector companies do provide information to their Federal counterparts, they do not really receive anything in return. It is like giving this information and there is not really getting much in return for that. So, they are somewhat of a disincentive to provide that information.

In addition, it is not always clear. They want to make sure that the information they do provide is sufficiently anonymized in order to allow it to be used by government agencies in an appropriate manner and not necessarily be shared with others.

Chairman JOHNSON. Let me talk about that personal information. In terms of preventing further attacks, in other words, that threat signature, there is really no reason to have personal information attached to that information that is shared, correct?

Mr. WILSHUSEN. I would say, generally, that would be the case.

Chairman JOHNSON. But, if you actually want to solve the crime, if you want to trace back, where did that hacking come from—which, quite honestly, to prevent further attacks, it would be awful nice to find out who these bad actors are, who the criminals are—that is where you need some personal information, potentially. How much can we limit that?

Mr. WILSHUSEN. Well, part of the what you would need would be, for example, the IP addresses from which these attacks are originating. And, so, while that may not be considered personally identifiable information, it is a key part of trying to trace attacks and the sources of those attacks.

Chairman JOHNSON. OK. Oh, Senator Carper is back. He has returned. I have no further questions. Senator Carper.

Senator CARPER. Thanks so much.

Some days are busier than others. This is a day where, when my train finally got here, I had the opportunity to participate with you and Senator Johnson and others in a press conference announcing the updated list the High-Risk List. And then we have almost simultaneously a markup and we are voting on legislation, part of which I authored, in the Finance Committee, and defending, and the Environment and Public Works Committee is having a hearing as we speak on clean air legislation, which is very important to my State, which is threatened by rising seas, and this important hearing. So, there is a lot going on. People from Delaware want to see me. And, so, I apologize for being in and out.

People sometimes say to me, I do not know if they say to Ron, but they say, "Can we come to Washington and meet with you?" And, I say, my life here is frenetic. Why do we not meet in Delaware? I go there every night. But, thank you for bearing with us.

I want to ask you a question about the Federal workforce, but before I do, let me preface it by making this observation. One of the pieces of cybersecurity legislation that this Committee adopted, reported out, and was ultimately signed into law by the President was one that strengthens the ability of the Department of Homeland Security to hire people, well-qualified people, to better enable them to help defend not only the Federal dot-gov world, but also to help businesses, the private sector and others, to defend their personally identifiable information, their intellectual property, and to give the Homeland Security Department actually the ability to do some of the hiring and retention for employees that they have not been able to do.

When I was Governor of Delaware, we used to lament the fact that on IT projects, we would hire people to work in the IT world for us, train them, they would become better and more proficient, and then they would get hired away. And, the same kind of thing actually happens with the Department of Homeland Security with their cyber warriors and they have asked for the tools to enable them to hire good people, retain people, and we have done that, and I am pleased the President has signed that. It is one of three or four pieces of legislation that has actually come through this Committee, signed into law last year, that will strengthen our cybersecurity.

But, with respect to the Federal workforce, as your report highlights, there are gaps in mission critical skills in the Federal workforce and they have significant impact on many of the high-risk issues. Unfortunately, efforts to identify and address current and emerging critical skill gaps have been slow and not fully successful. Addressing these gaps needs to be a priority, given their impact on so many important issues facing our country.

Let me just ask what strategies you think have been most successful. What strategies have been most successful in identifying and addressing those skill gaps, and how can we help to ensure that the Office of Personnel Management—and other agencies, too—are using the best strategies and giving this issue the focus that it deserves?

Mr. DODARO. First, I think the efforts need to recognize the skill gaps. I mean, we have pointed out this to a number of agencies and it is almost like they are not identifying them proactively on their own as much or using available authorities for retention and recruitment that could be used in the process. So, the first thing is sort of an awareness they have an issue, and also planning ahead for the future to be able to do this. At the same time you have critical skill gaps, you also have succession planning problems throughout the Federal Government because of the retirement of the Baby Boom generation. So, you have a dual problem that needs to be dealt with.

Chris Mihm is our expert in these areas. I will ask him to elaborate on some specific best practices. But, this area worries me as much as any on the list because it really goes to the heart of the government's ability to effectively function, and you cannot do it without the right people, whether you are talking about petroleum engineers and making sure we are getting our right oil and gas estimates, cost estimating expertise at NASA, the right people in a lot of these different departments and agencies, cybersecurity you mentioned. So, it is a real critical issue. I am glad that you asked the question.

Senator CARPER. All right. Thank you.

Mr. DODARO. Chris.

Mr. MIHM. Thank you, Senator. I agree very much with the preface of your question, that many of the High-Risk Issues that we find, a root cause of that is a critical skills gap in agencies. You had a discussion this morning about the problems over at VA. One of the five areas that you have heard about is a skills gap issue associated with training of staff over there. Skills gaps are certainly a big part of the acquisition area, in the acquisition workforce, notwithstanding an awful lot of attention that Congress and other agencies have given to that. The IT area, as you referenced in your question.

When we see the successful efforts to get at this, it is actually the two things the Comptroller General just mentioned. First, it is heavy use of data analytics. There is a wealth of Federal personnel information that is in our personnel files that is not being effectively mined. We talk all the time about big data. One of the big data things that we are not effectively exploiting is Federal personnel information, stripping out all the PII, of course. But, it can tell about career paths and training and development and exactly what are the succession planning challenges that an agency should be expecting. So, mining this big data that is out there on Federal personnel is one of the first key steps.

The second, as the Comptroller General also mentioned, is really effective strategic human capital planning. All too often in agencies, we go in and they seem to have a succession planning approach that goes under the very inelegant name of what is called

"truck sensitive," meaning if a truck hit the person, they know who is next in line. They are not thinking very far——

Senator CARPER. I like that, truck sensitive.

Mr. MIHM. Well, unless you are the one that is being hit on.

Senator CARPER. Senator, what did you get out of your hearing today? Well, truck sensitive.

Mr. MIHM. Well, here to contribute.

Senator CARPER. Among other things. [Laughter.]

Mr. MIHM. Well, but they are not thinking, what are the knowledge and skills that we are going to need to be effective 5, 10, and even 15 years in the future. We need to start recruiting on that now. We need to start training based on those skills now. We need to start developing those skills now. We cannot have a government where the working assumption is, the key to our future success is to be more like we are today. Many of the personnel systems that we have, certainly the human capital planning systems, seem to be implicit on that, is that if we just hire the same people that were just like us, we are going to be successful in the future. That is not going to be workable in the context that we face today.

Senator CARPER. All right. Thank you.

Last question and I will make it real quick and I will ask for a short answer. This year's High-Risk Report discusses improvement in a number of High-Risk Areas. We are grateful for that. Unfortunately, no issues, I think, were removed from the list from last year. Are there issues on the list that you think are within striking distance of being removed from the list, maybe, by 2017? And, for those issues, are there any things that come to mind that you think are the final reforms that are needed? Just touch on one or two, if you would.

Mr. DODARO. Sure. I am very pleased with the progress that we have made working with NASA on their acquisitions area. The big challenge now is to get as many people trained up as possible in their cost estimating and using Earned Value Management techniques and issues.

The big hang-up we have had with NASA is to agree on an approach to evaluate the design sophistication of their technology and the stability of it early in the process, before it develops along time, and they have implemented that for a number of their smaller projects. The big issue will be, can they extend that on their big major projects, like the James Webb telescope, the Space Launch System, the Orion capsule. So, we have been working with them. But, they have met, right now, three of the five criteria and they have top-level attention. They have a good plan. The question is whether they can execute over a period of time.

I also believe the Department of Homeland Security is within this if they stay the course in those areas. They really have to improve their acquisition area, though. I am really concerned about that. That is one that they have been late in implementing. And, they have to improve their internal controls environment and deal with their morale issues over there. I mean, those are three. You need a workforce that is more engaged and feeling better about themselves to be successful over a period of time. You cannot have the situation that they have right now and be successful. No business would be successful with that level of dissatisfaction and no

government agency will, as well. But, so, there are challenges there in those areas.

So, those are two that I would mention off the top of my head that are successful and, I think, doable within a reasonable period of time.

Senator CARPER. Good. Mr. Chairman, I would just say that, in closing, what Gene has said reminds me oh how important the work is we have done to try to vet and clear and send on to the Senate the leadership team that the President has asked for and Jeh Johnson has asked for in that Department. There is one more that we are working on, a fellow named Russ Deyo, who we have a lot of respect for. He has been nominated for the No. 3 position there, for management, and it is critically important that he be there.

I will close with—you mentioned NASA, and Mr. Chairman, you may have heard this story, and Tammy, you may have heard this story. A friend of mine was going through visiting NASA one night. Most of the people had left and gone home for the day. This one guy was still there working, and he was the janitor. And my friend said to him, "What do you do here? What is your job?" And, the man said, "I am helping to put a man on the moon."

The folks that are working at NASA to help make sure that they cleanup their performance with respect to high-risk, they are helping to put men and women not on the moon, but all over the galaxy and to do good things for our country. So, that is kind of making it real. Thanks so much.

Chairman JOHNSON. Well, we certainly share that commitment to make sure the agencies have the best people working for them, and I continue—I have said this repeatedly—I am very impressed with the people who work for the Federal Government. Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman, Ranking Member. I did not expect to have a chance to return from the Budget Committee, but, indeed, I am here, and I appreciate the chance for another opportunity to ask a question that I was going to submit for the record.

GAO found that local VA facilities are carrying out processes inconsistently, including those dealing with the provision of medical care. A GAO report from November 2014 found that about 10 percent of veterans who received health care services through the VA were diagnosed with major depressive disorder, and of those, 94 percent were prescribed an antidepressant. VA policy states that antidepressant treatment must be consistent with the VA's current clinical practices guideline. However, the GAO's review of medical records identified deviations from those guidelines for most veterans reviewed, and I will quote the report now. "As a result, VA does not know the extent to which veterans with major depressive disorder who have been prescribed antidepressants are receiving care as recommended in the clinical practice guidelines and, whether appropriate actions are taken by VAMCs to mitigate potentially significant risks to veterans."

In other words, the VA does not know if veterans with severe mental illnesses are getting the correct care. This is completely unacceptable, and I am extremely concerned that the VA may have

a similar blind spot regarding the appropriate standard of care for mental health patients at the Tomah VA, as I have outlined earlier today.

Indeed, in a tragic example last August, former Marine Jason Simcakoski died as an inpatient at the Tomah facility from mixed drug toxicity. At the time of his death, he reportedly was on 15 different prescription drugs, including antipsychotics, tranquilizers, muscle relaxants, and opioid painkillers. There are serious questions as to whether Mr. Simcakoski was receiving the correct standard of care, and your reports would indicate that the VHA's mental health treatment programs, including the drugs prescribed to patients, are deeply flawed.

So, I would love it if you could take a moment to explain these findings from the November 2014 GAO report in further detail and provide recommendations regarding how the VHA can fix this problem as soon as possible.

Mr. DODARO. Debbie.

Ms. DRAPER. Sure. We looked at a sample of medical records from six different VA Medical Centers and we did find exactly what you had talked about, and I think this really still gets at the issue of why we are putting VA Health Care on the High-Risk List. There are issues around oversight and accountability. Training is an issue, looking at how practices play out at the local level. Again, there are inconsistent processes and ambiguous policy.

So, in this report, we did make a number of recommendations to VA, and one was to implement processes to review the data and assess deviations from recommended care, because it was a large number of the records that we reviewed, they deviated from the clinical practice guideline, and that included things like a necessary initial review of the situation and then a followup review. Those were not conducted as they were outlined in the clinical practice guideline.

We also made recommendations—because in that same report, we looked at the template that was used to complete information about suicides and that information was also found to be incomplete. So, what happens is that it really diminishes VA's ability because they do not have complete data when they develop processes or initiatives on suicide prevention. So, we made a number of recommendations related to ensuring the completeness of that information, as well.

Chairman JOHNSON. Thank you, Senator Baldwin.

Mr. Dodaro, again, thank you and all of the associates from the GAO that have come here and provided some good information for all your good works. You can tell by the level of attendance at this hearing, you can tell by the level of engagement—it might be an overstatement, but this is this Committee's favorite agency. You do so much good work, and we truly appreciate that.

From my standpoint, one of the major take-aways, of course, is we are going to be supportive of making sure the recommendations of the VA get implemented as quickly as possible. But, also, we are looking at what we can do to develop a process to ensure implementation of as many of your recommendations, or all of your recommendations, across the agency. So, we want to work very closely with you on that process.

I was handed an interesting little fact. I talked about how you actually were suffering budget cuts. I guess last year, GAO had the fewest number of employees since World War II. Now, the Federal Government has kind of grown a little bit since World War II, so I think we would like to give you some more resources and some more associates to continue your good work and expand it so we can implement your recommendations.

So, again, thank you for your testimony. Thank you for all your good work.

This hearing record will remain open for 15 days, until February 26 at 5 p.m., for the submission of statements and questions for the record.

Senator CARPER. Mr. Chairman, just one quick closing comment. If you read the Preamble—in fact, we all learned it as kids in school, the Preamble to the Constitution—and one part of it says, "In order to form a more perfect Union"—"In order to form a more perfect Union." It does not say, "In order to form a perfect Union," but it does say, "In order to form a more perfect Union."

What you and the folks that are sitting there behind you in the front rows of this hearing room are trying to do is to help us form a more perfect Union. We know we will never be perfect. But we strive for perfection, because we know everything that we do, we can do better.

This is a team sport. You are critical members of the team. We like to think that we are, as well. Others within the agencies spread across the government, the President, OMB, we are all members of the team, and it is important that we pull together in the same direction, because if we do, some amazing things can happen. In fact, they already have, and we need more of that. Thank you so much.

Mr. DODARO. Thank you very much.

Chairman JOHNSON. Thank you, Senator Carper.

In manufacturing, good operations always engage in continuous improvement. GAO helps the government continuously improve, so, again, we thank you.

This hearing is adjourned.

[Whereupon, at 12:01 p.m., the Committee was adjourned.]

APPENDIX

Opening Statement of Chairman Ron Johnson
"Risky Business: Examining GAO's 2015 List of High Risk Government Programs"
February 11, 2015

As prepared for delivery:

Good morning and welcome.

This morning, the Government Accountability Office (GAO) released an update to its list of "High Risk" government operations. GAO has put out a High Risk Report at the beginning of every new Congress since 1990 to inform our oversight and legislative agenda and to focus national attention on the most pressing problems facing the federal government.

The pressure to transform agencies and programs designated as high risk has a real, measurable benefit to the taxpayer. By holding hearings like this one, and through follow up oversight and legislation to address the problems highlighted in this report, we have the potential to save tens of billions of dollars.

Over the last two years, GAO estimates that Congressional and Executive Branch attention to the high risk areas has saved $40 billion.

The 2015 High Risk Report contains an important new high risk area: veterans' health care. It is obvious to all of us that there continue to be serious problems with the government's ability to provide health care to our nation's veterans. Back home in Wisconsin, these problems are becoming increasingly evident with new reports coming in every day. While there are many public servants at the VA who do their best to provide quality care to our nation's heroes, it is clear that a lack of oversight and longstanding bureaucratic mismanagement has led to the systemic problems that have put our veterans at risk.

The work GAO has done to not only bring these issues to the national stage, but to also work year-round behind the scenes with federal agencies to actually start the process of fixing these problems deserves our highest praise.

I look forward to hearing from the head of GAO, Comptroller General Gene Dodaro, about what we in Congress can do to address these longstanding problems through legislation and oversight.

Opening Statement of Ranking Member Thomas R. Carper
"Risky Business: Examining GAO's 2015 List of High Risk Government Programs"
February 11, 2015

As prepared for delivery:

Last November, the voters went to the polls and sent us a clear message. They want the Members of Congress to stop bickering, come together to solve problems, and help continue our economic recovery. That's exactly what we're doing here today. We're coming together to talk about how we can solve the problems that the Government Accountability Office (GAO) is naming today as the 'highest-risk' for our government, which I have long considered Congress' 'to-do' list.

What GAO means is that if we don't solve these problems, the taxpayers are exposed to a high level of waste, fraud or abuse, which can cost our government billions of dollars every year. GAO's report also points to needed reforms in many critical government operations that provide for the security, health and safety of the American people.

We can solve all the problems on the High Risk list. But it is a shared responsibility. Congress must leverage the good work of GAO and the Inspectors General across the government, and work closely with the Office of Management and Budget and the agencies responsible for these programs.

GAO's report being released today shows that kind of strategy is working in several High Risk areas. In fact, GAO reports that 18 of the 30 areas on the 2013 list have shown improvement. This includes progress in areas that we've worked on in this Committee, specifically cybersecurity, the sharing of information on terrorist threats, and the management of the Department of Homeland Security. Progress noted by GAO also includes the Department of Defense's management of its contracts and major weapons systems acquisitions. I am pleased that GAO has found solid progress in all these areas.

However, we still have much work to do on these and other High Risk areas. There are a lot of what I call 'repeat offenders' on the list – for example, waste and fraud in Medicare and Medicaid, chronic financial management problems at the Department of Defense, longstanding challenges in recruiting needed skills into the federal workforce, and the government's incredibly wasteful management of federal property.

These items' continued presence on the list is obviously disappointing and troubling, but it also underscores the urgent need to provide strong oversight, and work with the Administration to develop and implement solutions to address these risks.

I also want to point out that there are two new items on the High Risk list. One is an issue that has long been at the forefront of oversight and legislative attention from this Committee. That is the acquisition and management of information technology by the government. Last year I worked closely with Dr. Coburn, then-Chairman Issa and Congressman Connelly to enact the Federal Information Technology Acquisition Reform

Act, FITARA. FITARA will strengthen the roles of Chief Information Officers across the government and will give them better tools to manage IT investments. I now will work closely with Chairman Johnson and our House colleagues to make sure that FITARA is implemented properly.

And as all Americans know, there are many serious problems with the health care that the federal government delivers to our nation's veterans. It is no surprise that GAO is adding this to the High Risk list. Last year, Congress came together and passed legislation to address the immediate problem of veterans having to wait too long to access care through the Veterans Administration. However, much more remains to be done to ensure that veterans get timely, high-quality, and cost-effective health care. Our veterans deserve no less.

I want to close by emphasizing the clear role that Congress must play in these High Risk areas. Federal agencies need adequate resources and, in many cases, new authorities from Congress to be able to tackle these problems. I can't think of two better examples than two that are at the top of my agenda for this Congress – restructuring the U.S. Postal Service and funding the nation's surface transportation system. It is up to Congress to act.

I thank Gene Dodaro, our Comptroller General of GAO, for the hard work that he and his team have done to put together this year's 'High Risk' list. The release of this list every two years is always sobering, because it's a reminder of the many serious challenges that face our government. But I also find that the release of the report serves as important encouragement to the executive branch and Congress because the report highlights the progress that is being made, and shows the path for further progress. So, Mr. Dodaro, I'm ready for you to give us our 'to-do' list, and Mr. Chairman, I know we are going to have a productive Congress and make great progress in making the High Risk list a shorter list.

###

Senate Homeland Security and Government Affairs Committee
Full Committee Hearing – Risky Business Examining GAO's 2015 List of High Risk Government Programs
Statement for the Record
Senator Joni Ernst
February 11, 2015

Chairman Johnson and Ranking Member Carper:

Thank you for holding this important hearing on our government's most vulnerable programs. Oversight of our federal programs is a role I take seriously. I look forward to working with my colleagues on both sides of the aisle to ensure we are spending taxpayer dollars judiciously, and are improving the efficiency and management of these programs.

Unfortunately, I was unable to stay to ask questions of the witnesses due to commitments at a Senate Armed Services Committee hearing on the current situation in Afghanistan. However, I will be submitting questions for the record.

Thank you.

United States Government Accountability Office

Testimony
Before the Committee on Homeland Security and Governmental Affairs, U.S. Senate

For Release on Delivery
Expected at 10 a.m. ET
Wednesday, February 11, 2015

GAO'S 2015 HIGH-RISK SERIES

An Update

Statement of Gene L. Dodaro
Comptroller General of the United States

February 2015

HIGH-RISK SERIES

An Update

GAO Highlights

Highlights of GAO-15-371T, a statement before the Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

The federal government is one of the world's largest and most complex entities; about $3.5 trillion in outlays in fiscal year 2014 funded a broad array of programs and operations. GAO maintains a program to focus attention on government operations that it identifies as high risk due to their greater vulnerabilities to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges.

Since 1990, more than one-third of the areas previously designated as high risk have been removed from the list because sufficient progress was made in addressing the problems identified. The five criteria for removal are: (1) leadership commitment, (2) agency capacity, (3) an action plan, (4) monitoring efforts, and (5) demonstrated progress.

This biennial update describes the status of high-risk areas listed in 2013 and identifies new high-risk areas needing attention by Congress and the executive branch. Solutions to high-risk problems offer the potential to save billions of dollars, improve service to the public, and strengthen government performance and accountability.

What GAO Recommends

This report contains GAO's views on progress made and what remains to be done to bring about lasting solutions for each high-risk area. Perseverance by the executive branch in implementing GAO's recommended solutions and continued oversight and action by Congress are essential to achieving greater progress.

View GAO-15-371T. For more information, contact J. Christopher Mihm at (202) 512-6806 or mihmj@gao.gov

What GAO Found

Solid, steady progress has been made in the vast majority of the high-risk areas. Eighteen of the 30 areas on the 2013 list at least partially met all of the criteria for removal from the high risk list. Of those, 11 met at least one of the criteria for removal and partially met all others. Sufficient progress was made to narrow the scope of two high-risk issues—*Protecting Public Health through Enhanced Oversight of Medical Products* and *DOD Contract Management*. Overall, progress has been possible through the concerted actions of Congress, leadership and staff in agencies, and the Office of Management and Budget.

This year GAO is adding 2 areas, bringing the total to 32.

- **Managing Risks and Improving Veterans Affairs (VA) Health Care.** GAO has reported since 2000 about VA facilities' failure to provide timely health care. In some cases, these delays or VA's failure to provide care at all have reportedly harmed veterans. Although VA has taken actions to address some GAO recommendations, more than 100 of GAO's recommendations have not been fully addressed, including recommendations related to the following areas: (1) ambiguous policies and inconsistent processes, (2) inadequate oversight and accountability, (3) information technology challenges, (4) inadequate training for VA staff, and (5) unclear resource needs and allocation priorities. The recently enacted Veterans Access, Choice, and Accountability Act included provisions to help VA address systemic weaknesses. VA must effectively implement the act.
- **Improving the Management of Information Technology (IT) Acquisitions and Operations.** Congress has passed legislation and the administration has undertaken numerous initiatives to better manage IT investments. Nonetheless, federal IT investments too frequently fail to be completed or incur cost overruns and schedule slippages while contributing little to mission-related outcomes. GAO has found that the federal government spent billions of dollars on failed and poorly performing IT investments which often suffered from ineffective management, such as project planning, requirements definition, and program oversight and governance. Over the past 5 years, GAO made more than 730 recommendations; however, only about 23 percent had been fully implemented as of January 2015.

GAO is also expanding two areas due to evolving high-risk issues.

- **Enforcement of Tax Laws.** This area is expanded to include IRS's efforts to address tax refund fraud due to identify theft. IRS estimates it paid out $5.8 billion (the exact number is uncertain) in fraudulent refunds in tax year 2013 due to identity theft. This occurs when a thief files a fraudulent return using a legitimate taxpayer's identifying information and claims a refund.
- **Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting the Privacy of Personally Identifiable Information (PII).** This risk area is expanded because of the challenges to ensuring the privacy of personally identifiable information posed by advances in technology. These advances have allowed both government and private sector entities to collect and process extensive amounts of PII more effectively. The number of reported security incidents involving PII at federal agencies has increased dramatically in recent years.

GAO's 2015 High Risk List

Strengthening the Foundation for Efficiency and Effectiveness
• Limiting the Federal Government's Fiscal Exposure by Better Managing Climate Change Risks
• Management of Federal Oil and Gas Resources
• Modernizing the U.S. Financial Regulatory System and the Federal Role in Housing Finance[a]
• Restructuring the U.S. Postal Service to Achieve Sustainable Financial Viability[a]
• Funding the Nation's Surface Transportation System[a]
• Strategic Human Capital Management
• Managing Federal Real Property
• Improving the Management of IT Acquisitions and Operations **(new)**
Transforming DOD Program Management
• DOD Approach to Business Transformation
• DOD Business Systems Modernization
• DOD Support Infrastructure Management[a]
• DOD Financial Management
• DOD Supply Chain Management
• DOD Weapon Systems Acquisition
Ensuring Public Safety and Security
• Mitigating Gaps in Weather Satellite Data
• Strengthening Department of Homeland Security Management Functions
• Establishing Effective Mechanisms for Sharing and Managing Terrorism-Related Information to Protect the Homeland
• Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting the Privacy of Personally Identifiable Information[a]
• Ensuring the Effective Protection of Technologies Critical to U.S. National Security Interests[a]
• Improving Federal Oversight of Food Safety[a]
• Protecting Public Health through Enhanced Oversight of Medical Products
• Transforming EPA's Processes for Assessing and Controlling Toxic Chemicals[a]
Managing Federal Contracting More Effectively
• DOD Contract Management
• DOE's Contract Management for the National Nuclear Security Administration and Office of Environmental Management
• NASA Acquisition Management
Assessing the Efficiency and Effectiveness of Tax Law Administration
• Enforcement of Tax Laws[a]
Modernizing and Safeguarding Insurance and Benefit Programs
• Managing Risks and Improving VA Health Care **(new)**
• Improving and Modernizing Federal Disability Programs
• Pension Benefit Guaranty Corporation Insurance Programs[a]
• Medicare Program[a]
• Medicaid Program[a]
• National Flood Insurance Program[a]

Source: GAO. | GAO-15-371T

[a]Legislation is likely to be necessary to effectively address this high-risk area.

Chairman Johnson, Ranking Member Carper, and Members of the Committee:

Thank you for the opportunity to discuss our 2015 high-risk update.[1] Since 1990, we have regularly reported on government operations that we have identified as high risk due to their greater vulnerability to fraud, waste, abuse, and mismanagement or the need for transformation to address economy, efficiency, or effectiveness challenges. Our high-risk program, supported by this Committee and the House Committee on Oversight and Government Reform, has brought much-needed focus to problems impeding effective government and costing billions of dollars each year.

Since our last high-risk update in 2013, solid, steady progress has been made in the vast majority of areas that remain on the list. Since 1990, more than one-third of the areas previously designated as high risk have been removed from the High Risk List because sufficient progress was made in addressing the problems identified. Nonetheless, 11 issues have been on the High Risk List since the 1990s and 6 of these were on our original list of 14 areas in 1990.

Congressional oversight and legislative action have been critical to the progress that has been made. Congress passed numerous laws targeting both specific problems and the high-risk areas overall. In addition, top administration officials have continued to show their commitment to ensuring that high-risk areas receive attention and oversight. The Office of Management and Budget (OMB) regularly convenes meetings with agency leaders and GAO to discuss progress updates on high-risk issues. This year, due to significant progress made, we narrowed the high-risk designation for two areas—*Protecting Public Health Through Enhanced Oversight of Medical Products* and *DOD Contract Management*.

We also designated two new high-risk areas this year—*Managing Risks and Improving VA Health Care* and *Improving the Management of IT Acquisitions and Operations*. Lasting solutions to these and the other 30 high-risk areas offer the potential to save billions of dollars, dramatically improve service to the American public, and strengthen public confidence

[1]GAO, *High Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

and trust in the performance and accountability of our national government.

While there has been notable progress, much remains to be done to address the 32 high-risk issues that are currently on our High Risk List. Our high risk update report and website provide details for each of these issues, describing the nature of the risks, what actions have been taken to address them, and what remains to be done to make further progress.[2] The details in our report, along with successful implementation by agencies and continued oversight by Congress, can form a solid foundation for progress to address risks and improve programs and operations.

New High-Risk Areas for 2015

To determine which federal government programs and functions should be added to the High Risk List, we consider whether the program or function is of national significance or is key to government performance and accountability. Further, we consider qualitative factors, such as whether the risk

- involves public health or safety, service delivery, national security, national defense, economic growth, or privacy or citizens' rights, or
- could result in significant impaired service, program failure, injury or loss of life, or significantly reduced economy, efficiency, or effectiveness.

In addition, we also review the exposure to loss in quantitative terms such as the value of major assets being impaired, revenue sources not being realized, or major agency assets being lost, stolen, damaged, or wasted. We also consider corrective measures planned or under way to resolve a material control weakness and the status and effectiveness of these actions.

This year, we added two new areas, delineated below, to the High Risk List based on those criteria.

[2]GAO's high risk website, http://www.gao.gov/highrisk/.

Managing Risks and Improving VA Health Care

In response to serious and long-standing problems with veterans' access to care, which were highlighted in a series of congressional hearings in the spring and summer of 2014, Congress enacted the Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. No. 113-146, 128 Stat. 1754), which provides $15 billion in new funding for Department of Veterans Affairs (VA) health care. Generally, this law requires VA to offer veterans the option to receive hospital care and medical services from a non-VA provider when a VA facility cannot provide an appointment within 30 days, or when veterans reside more than 40 miles from the nearest VA facility. Under the law, VA received $10 billion to cover the expected increase in utilization of non-VA providers to deliver health care services to veterans. The $10 billion is available until expended and is meant to supplement VA's current budgetary resources for medical care. Further, the law appropriated $5 billion to increase veterans' access to care by expanding VA's capacity to deliver care to veterans by hiring additional clinicians and improving the physical infrastructure of VA's facilities. It is therefore critical that VA ensures its resources are being used in a cost-effective manner to improve veterans' timely access to health care.

We have categorized our concerns about VA's ability to ensure the timeliness, cost-effectiveness, quality, and safety of the health care the department provides into five broad areas: (1) ambiguous policies and inconsistent processes, (2) inadequate oversight and accountability, (3) information technology challenges, (4) inadequate training for VA staff, and (5) unclear resource needs and allocation priorities. We have made numerous recommendations that aim to address weaknesses in VA's management of its health care system—more than 100 of which have yet to be fully resolved. For example, to ensure that its facilities are carrying out processes at the local level more consistently—such as scheduling veterans' medical appointments and collecting data on veteran suicides—VA needs to clarify its existing policies. VA also needs to strengthen oversight and accountability across its facilities by conducting more systematic, independent assessments of processes that are carried out at the local level, including how VA facilities are resolving specialty care consults, processing claims for non-VA care, and establishing performance pay goals for their providers. We also have recommended that VA work with the Department of Defense (DOD) to address the administrative burdens created by the lack of interoperability between their two IT systems. A number of our recommendations aim to improve training for staff at VA facilities, to address issues such as how staff are cleaning, disinfecting, and sterilizing reusable medical equipment, and to more clearly align training on VA's new nurse staffing methodology with the needs of staff responsible for developing nurse staffing plans. Finally,

we have recommended that VA improve its methods for identifying VA facilities' resource needs and for analyzing the cost-effectiveness of VA health care.

The recently enacted Veterans Access, Choice, and Accountability Act included a number of provisions intended to help VA address systemic weaknesses. For example, the law requires VA to contract with an independent entity to (1) assess VA's capacity to meet the current and projected demographics and needs of veterans who use the VA health care system, (2) examine VA's clinical staffing levels and productivity, and (3) review VA's IT strategies and business processes, among other things. The new law also establishes a 15-member commission, to be appointed primarily by bipartisan congressional leadership, which will examine how best to organize the VA health care system, locate health care resources, and deliver health care to veterans. It is critical for VA leaders to act on the findings of this independent contractor and congressional commission, as well as on those of VA's Office of the Inspector General, GAO, and others, and to fully commit themselves to developing long-term solutions that mitigate risks to the timeliness, cost-effectiveness, quality, and safety of the VA health care system.

It is also critical that Congress maintains its focus on oversight of VA health care. In the spring and summer of 2014, congressional committees held more than 20 hearings to address identified weaknesses in the VA health care system. Sustained congressional attention to these issues will help ensure that VA continues to make progress in improving the delivery of health care services to veterans.

We plan to continue monitoring VA's efforts to improve the timeliness, cost-effectiveness, quality, and safety of veterans' health care. To this end, we have ongoing work focusing on topics such as veterans' access to primary care and mental health services; primary care productivity; nurse recruitment and retention; monitoring and oversight of VA spending on training programs for health care professionals; mechanisms VA uses to monitor quality of care; and VA and DOD investments in Centers of Excellence—which are intended to produce better health outcomes for veterans and service members.

Improving the Management of IT Acquisitions and Operations

Although the executive branch has undertaken numerous initiatives to better manage the more than $80 billion that is annually invested in information technology (IT), federal IT investments too frequently fail or incur cost overruns and schedule slippages while contributing little to mission-related outcomes. We have previously testified that the federal government has spent billions of dollars on failed IT investments. These and other failed IT projects often suffered from a lack of disciplined and effective management, such as project planning, requirements definition, and program oversight and governance. In many instances, agencies have not consistently applied best practices that are critical to successfully acquiring IT investments.

We have identified nine critical factors underlying successful major acquisitions that support the objective of improving the management of large-scale IT acquisitions across the federal government: (1) program officials actively engaging with stakeholders; (2) program staff having the necessary knowledge and skills; (3) senior department and agency executives supporting the programs; (4) end users and stakeholders involved in the development of requirements; (5) end users participating in testing of system functionality prior to end user acceptance testing; (6) government and contractor staff being stable and consistent; (7) program staff prioritizing requirements; (8) program officials maintaining regular communication with the prime contractor; and (9) programs receiving sufficient funding.[3]

While there have been numerous executive branch initiatives aimed at addressing these issues, implementation has been inconsistent. Over the past 5 years, we have reported numerous times on shortcomings with IT acquisitions and operations and have made about 737 related recommendations, 361 of which were to the Office of Management and Budget (OMB) and agencies to improve the implementation of the recent initiatives and other government-wide, cross-cutting efforts. As of January 2015, about 23 percent of the 737 recommendations had been fully implemented.

Given the federal government's continued experience with failed and troubled IT projects, coupled with the fact that OMB initiatives to help

[3]GAO, *Information Technology: Critical Factors Underlying Successful Major Acquisitions*, GAO-12-7 (Washington, D.C.: Oct. 21, 2011).

address such problems have not been fully implemented, the government will likely continue to produce disappointing results and will miss opportunities to improve IT management, reduce costs, and improve services to the public, unless needed actions are taken. Further, it will be more difficult for stakeholders, including Congress and the public, to monitor agencies' progress and hold them accountable for reducing duplication and achieving cost savings.

Recognizing the severity of issues related to government-wide management of IT, in December 2014 the Federal Information Technology Acquisition Reform provisions were enacted as a part of the Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act for Fiscal Year 2015. I want to acknowledge the leadership of this Committee and the House Committee on Oversight and Government Reform in leading efforts to enact this important legislation. To help address the management of IT investments, OMB and federal agencies should expeditiously implement the requirements of the December 2014 statutory provisions promoting IT acquisition reform.[4] Doing so should (1) improve the transparency and management of IT acquisitions and operations across the government, and (2) strengthen the authority of chief information officers to provide needed direction and oversight. To help ensure that these improvements are achieved, congressional oversight of agencies' implementation efforts is essential.

Beyond implementing the recently enacted law, OMB and agencies need to continue to implement our previous recommendations in order to improve their ability to effectively and efficiently invest in IT. Several of these are critical, such as

- conducting TechStat reviews for at-risk investments,
- updating the public version of the IT Dashboard throughout the year, and
- developing comprehensive inventories of federal agencies' software licenses.

[4]Howard P. 'Buck' McKeon National Defense Authorization Act for Fiscal Year 2015, Pub. L. No. 113-291, § 831(a) (Dec. 19, 2014).

To ensure accountability, OMB and agencies should also demonstrate measurable government-wide progress in the following key areas:

- OMB and agencies should, within 4 years, implement at least 80 percent of our recommendations related to the management of IT acquisitions and operations.
- Agencies should ensure that a minimum of 80 percent of the government's major acquisitions should deliver functionality every 12 months.
- Agencies should achieve no less than 80 percent of the over $6 billion in planned PortfolioStat savings and 80 percent of the more than $5 billion in savings planned for data center consolidation.

Expanding High-Risk Areas

In the 2 years since the last high-risk update, two areas have expanded in scope. *Enforcement of Tax Laws* has been expanded to include IRS's efforts to address tax refund fraud due to identity theft. *Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure* has been expanded to include the federal government's protection of personally identifiable information and is now called *Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting Personally Identifiable Information (PII).*

Enforcement of Tax Laws

Since 1990, we have designated one or more aspects of *Enforcement of Tax Laws* as high risk. The focus of the *Enforcement of Tax Laws* high-risk area is on the estimated $385 billion net tax gap—the difference between taxes owed and taxes paid—and IRS's and Congress's efforts to address it. Given current and emerging risks, we are expanding the Enforcement of Tax Laws area to include IRS's efforts to address tax refund fraud due to identity theft (IDT), which occurs when an identity thief files a fraudulent tax return using a legitimate taxpayer's identifying information and claims a refund. While acknowledging that the numbers are uncertain, IRS estimated paying about $5.8 billion in fraudulent IDT refunds while preventing $24.2 billion during the 2013 tax filing season.

While there are no simple solutions to combating IDT refund fraud, we have identified various options that could help, some of which would require legislative action. Because some of these options represent a significant change to the tax system that could likely burden taxpayers and impose significant costs to IRS for systems changes, it is important for IRS to assess the relative costs and benefits of the options. This

assessment will help ensure an informed discussion among IRS and relevant stakeholders—including Congress—on the best option (or set of options) for preventing IDT refund fraud.

Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting the Privacy of Personally Identifiable Information

Since 1997, we have designated the security of our federal cyber assets as a high-risk area. In 2003, we expanded this high-risk area to include the protection of critical cyber infrastructure.

The White House and federal agencies have taken steps toward improving the protection of our cyber assets. However, advances in technology which have dramatically enhanced the ability of both government and private sector entities to collect and process extensive amounts of Personally Identifiable Information (PII) pose challenges to ensuring the privacy of such information. The number of reported security incidents involving PII at federal agencies has increased dramatically in recent years. In addition, high-profile PII breaches at commercial entities have heightened concerns that personal privacy is not being adequately protected. Finally, both federal agencies and private companies collect detailed information about the activities of individuals–raising concerns about the potential for significant erosion of personal privacy. We have suggested, among other things, that Congress consider amending privacy laws to cover all PII collected, used, and maintained by the federal government and recommended that the federal agencies we reviewed take steps to protect personal privacy and improve their responses to breaches of PII. For these reasons, we added the protection of privacy to this high-risk area this year.

Essential Elements for Addressing High-Risk Areas

Our experience with the high-risk series over the past 25 years has shown that five broad elements are essential to make progress.[5] The five criteria for removal are as follows:

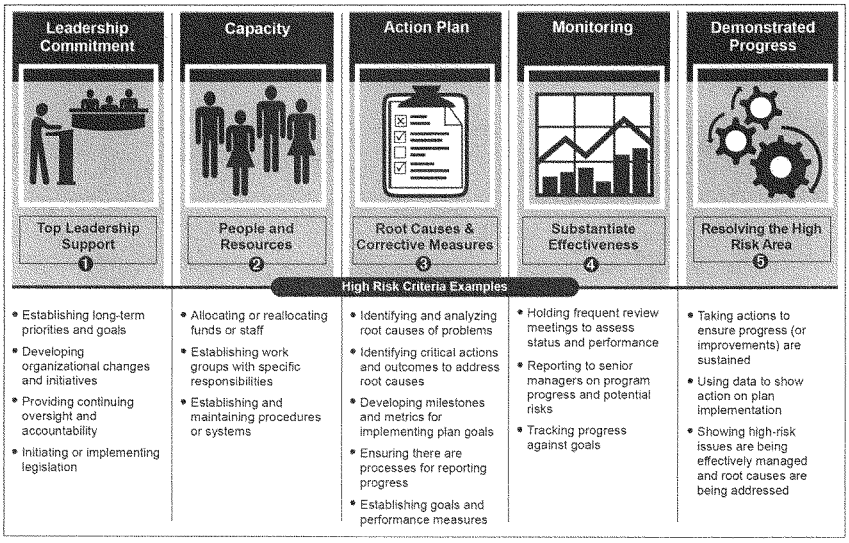
- **Leadership commitment.** Demonstrated strong commitment and top leadership support.
- **Capacity**. Agency has the capacity (i.e., people and resources) to resolve the risk(s).

[5]GAO, *Determining Performance and Accountability Challenges and High Risks*, GAO-01-159SP (Washington, D.C.: November 2000).

- **Action plan.** A corrective action plan exists that defines the root cause and solutions and that provides for substantially completing corrective measures, including steps necessary to implement solutions we recommended.
- **Monitoring**. A program has been instituted to monitor and independently validate the effectiveness and sustainability of corrective measures.
- **Demonstrated progress.** Ability to demonstrate progress in implementing corrective measures and in resolving the high-risk area.

These five criteria form a road map for efforts to improve and ultimately address high-risk issues. Addressing some of the criteria leads to progress, while satisfying all of the criteria is central to removal from the list. Figure 1 shows the five criteria and examples of actions taken by agencies to address the criteria. Throughout my statement and in our high-risk update report, we have detailed many actions taken to address the high-risk areas aligned with the five criteria as well as additional steps that need to be addressed.

Figure 1: Criteria for Removal from the High Risk List and Examples of Actions Leading to Progress



Source: GAO analysis of agencies' actions to address high-risk issues and GAO criteria for removal from the High Risk List in GAO-01-159SP | GAO-15-371T

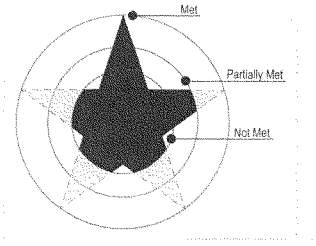
In each of our high-risk updates, for more than a decade, we have assessed progress to address the five criteria for removing the high-risk areas from the list. In this high-risk update, we are adding additional clarity and specificity to our assessments by rating each high-risk area's progress on the criteria, using the following definitions:

- **Met**. Actions have been taken that meet the criterion. There are no significant actions that need to be taken to further address this criterion.
- **Partially met.** Some, but not all, actions necessary to meet the criterion have been taken.

- **Not met.** Few, if any, actions towards meeting the criterion have been taken.

Figure 2 is a visual representation of varying degrees of progress in each of the five criteria for a high-risk area. Each point of the star represents one of the five criteria for removal from the High Risk List and each ring represents one of the three designations: not met, partially met, or met.

Figure 2: High-Risk Progress Criteria Ratings



Source: GAO. | GAO-15-371T

The progress ratings used to address the high-risk criteria are an important part of our efforts to provide greater transparency and specificity to agency leaders as they seek to address high-risk areas. Beginning in the spring of 2014 leading up to this high-risk update, we met with agency leaders across government to discuss preliminary progress ratings. These meetings focused on actions taken and on additional actions that need to be taken to address the high-risk issues. Several agency leaders told us that the additional clarity provided by the progress rating helped them better target their improvement efforts.

Continued Progress

Since our last high-risk update in 2013, there has been solid and steady progress on the vast majority of the 30 high-risk areas from our 2013 list. Progress has been possible through the concerted actions and efforts of Congress and the leadership and staff in agencies and OMB. As shown in table 1, 18 high-risk areas have met or partially met all criteria for removal from the list; 11 of these areas also fully met at least one criterion. Of the 11 areas that have been on the High Risk List since the 1990s, 7 have at least met or partially met all of the criteria for removal and 1 area—*DOD*

Contract Management—is 1 of the 2 areas that has made enough progress to remove subcategories of the high-risk area. Overall, 28 high-risk areas were rated against the five criteria, totaling a possible 140 high-risk area criteria ratings. Of these, 122 (or 87 percent) were rated as met or partially met. On the other hand, 13 of the areas have not met any of the five criteria; 3 of those—*DOD Business Systems Modernization, DOD Support Infrastructure Management*, and *DOD Financial Management*—have been on the High Risk List since the 1990's.

Table 1: High-Risk Areas Rated Against Five Criteria for Removal

High-risk area	Number of criteria		
	Met	Partially met	Not met
NASA Acquisition Management[a]	3	2	0
Establishing Effective Mechanisms for Sharing and Managing Terrorism-Related Information to Protect the Homeland	2	3	0
Protecting Public Health through Enhanced Oversight of Medical Products	2	3	0
Strengthening Department of Homeland Security Management Functions	2	3	0
DOD Contract Management[a]	1	4	0
DOD Supply Chain Management[a]	1	4	0
DOD Weapon Systems Acquisition[a]	1	4	0
Management of Federal Oil and Gas Resources	1	4	0
Medicare Program[a]	1	4	0
Mitigating Gaps in Weather Satellite Data	1	4	0
Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting the Privacy of Personally Identifiable Information[a]	1	4	0
DOD Support Infrastructure Management[a]	0	5	0
Ensuring the Effective Protection of Technologies Critical to U.S. National Security Interests	0	5	0
Improving and Modernizing Federal Disability Programs	0	5	0
Medicaid Program	0	5	0
Modernizing the U.S. Financial Regulatory System and Federal Role in Housing Finance	0	5	0
National Flood Insurance Program	0	5	0
Restructuring the U.S. Postal Service to Achieve Sustainable Financial Viability	0	5	0
Enforcement of Tax Laws[a]	1	3	1
Managing Federal Real Property	1	3	1
DOD Business Systems Modernization[a]	0	4	1
Strategic Human Capital Management	0	4	1
Transforming EPA's Processes for Assessing and Controlling Toxic Chemicals	1	2	2

High-risk area	Number of criteria		
	Met	Partially met	Not met
DOD Financial Management [a]	0	3	2
Limiting the Federal Government's Fiscal Exposure by Better Managing Climate Change Risks	0	3	2
Improving Federal Oversight of Food Safety	0	3	2
DOE's Contract Management for the National Nuclear Security Administration and Office of Environmental Management [a]	1	1	3
DOD Approach to Business Transformation	0	2	3
Funding the Nation's Surface Transportation System	N/A	N/A	N/A
Improving the Management of IT Acquisitions and Operations	N/A	N/A	N/A
Managing Risks and Improving VA Health Care	N/A	N/A	N/A
Pension Benefit Guaranty Corporation Insurance Programs	N/A	N/A	N/A

Legend: N/A = Not applicable.

Source: GAO. | GAO-15-371T

Note: Four high-risk areas that received a "not applicable" rating because (1) they are either new to our 2015 High-Risk List (*Managing Risks and Improving VA Health Care* and *Improving the Management of IT Acquisitions and Operations*) or (2) addressing the high risk area primarily involves congressional action and the high risk criteria and subsequent ratings were developed to reflect the status of agencies' actions and the additional steps they need to take (*Funding the Nation's Surface Transportation System and Pension Benefit Guaranty Corporation Insurance Programs*).

[a] = issue has been on the high risk list since the 1990s.

Throughout the history of the high-risk program, Congress played an important role through its oversight and (where appropriate) through legislative action targeting both specific problems and the high-risk areas overall. Since our last high-risk report, several high-risk areas have received congressional oversight and legislation needed to make progress in addressing risks. Table 2 provides examples of congressional actions and of high-level administration initiatives—discussed in more detail throughout our report—that have led to progress in addressing high-risk areas. Additional congressional actions and administrative initiatives are also included in the individual high-risk areas discussed in this report.

Table 2: Selected Examples of Congressional Actions and Administration Initiatives Leading to Progress on High-Risk Areas

High-risk area	Selected example
Mitigating Gaps in Weather Satellite Data	In January 2013, Congress passed the **Disaster Relief Appropriations Act, 2013**, which contained $111 million in funding for satellite gap mitigation projects. According to National Oceanic and Atmospheric Administration officials, this amount was reduced by 5 percent due to budget cuts related to sequestration.
Protecting Public Health through Enhanced Oversight of Medical Products	Congress enacted the **Drug Quality and Security Act in November 2013**, which contains provisions that should help the Food and Drug Administration respond to challenges in two distinct areas that we reported on in July 2013: (1) the hazards posed by unsafe drugs from an increasingly complex pharmaceutical supply chain that includes rogue Internet pharmacies and (2) the public health threat posed by improperly compounded drugs.
Pension Benefit Guaranty Corporation (PBGC) Insurance Programs	In December 2014, Congress took action to address the growing crisis in the multiemployer pension system with passage of the **Multiemployer Pension Reform Act of 2014**, which enacted several reforms responsive to our 2013 report on PBGC's multiemployer program. The act provided severely underfunded plans, under certain conditions and with the approval of federal regulators, the option to reduce the retirement benefits of current retirees to avoid plan insolvency and expand PBGC's ability to intervene when plans are in financial distress. While these reforms are intended to improve the program's financial condition, the future insolvency of the multiemployer program remains likely. In addition, to help address PBGC's overall deficit, the **Bipartisan Budget Act of 2013** increased premium rates for the single-employer program and the Multiemployer Pension Reform Act increased premiums for the multiemployer program.
Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting the Privacy of Personally Identifiable Information	In December 2014, five cybersecurity-related bills were enacted into law. (1) The **Federal Information Security Modernization Act of 2014** revised the Federal Information Security Management Act of 2002. Among other things, it gave the Department of Homeland Security (DHS) responsibilities to assist the Office of Management and Budget (OMB) in overseeing civilian agency information security policies and practices for information systems. In addition, it requires agencies to include automated tools in periodic testing of systems and expands requirements for reporting major incidents and data breach notifications. (2) The **Cybersecurity Workforce Assessment Act** requires DHS to assess its cybersecurity workforce and develop a comprehensive strategy to enhance the readiness, capacity, training, recruitment, and retention of its cybersecurity workforce. (3) The **Homeland Security Cybersecurity Workforce Assessment Act** requires DHS to identify cybersecurity positions and the specialty areas of critical need in the DHS cybersecurity workforce. (4) The **National Cybersecurity Protection Act of 2014** codifies the role of DHS's National Cybersecurity and Communications Integration Center, a 24x7 cyber situational awareness, incident response and management center that is a national nexus of cyber and communications integration for the federal government, intelligence community, and law enforcement. (5) The **Cybersecurity Enhancement Act of 2014** authorizes the Department of Commerce, through the National Institute of Standards and Technology, to facilitate and support the development of voluntary standards to reduce cyber risks to critical infrastructure. The law also requires the Office of Science and Technology Policy in the Executive Office of the President to facilitate agencies' development of a federal cybersecurity research and development plan.
DOD Approach to Business Transformation	The **Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act for Fiscal Year 2015** converted the Deputy Chief Management Officer to the Under Secretary of Defense for Business Management and Information. The Under Secretary of Defense for Business Management and Information will assist the Deputy Secretary of Defense in his role as the Chief Management Officer. The Under Secretary of Defense for Business Management and Information will also serve as the Chief Information Officer and Performance Improvement Officer for the Department of Defense. These changes will take effect on February 1, 2017.

High-risk area	Selected example
DOD Financial Management	The **National Defense Authorization Act (NDAA) for Fiscal Year 2013** required the Financial Improvement and Audit Readiness Plan to state the actions taken to ensure validation of the audit readiness of the Department of Defense (DOD) Statement of Budgetary Resources no later than September 30, 2014. Although the November 2014, Financial Improvement and Audit Readiness Plan Status Report acknowledges that DOD has not met that date, Congress' action to set a specific date for the goal of DOD audit readiness is important for holding DOD accountable for progress. Congress further strengthened accountability in the **NDAA for Fiscal Year 2014** by requiring a full audit of DOD's fiscal year 2018 financial statements and for those results to be submitted to Congress no later than March 31, 2019.
Strengthening Department of Homeland Security Management Functions	The Department of Homeland Security (DHS) has established various initiatives collectively intended to improve its unity of effort by, among other things, improving the department's planning, programming, budgeting, and execution processes through strengthened departmental structures and increased capability. In addition, DHS has increased component-level acquisition capability by, among other things, initiating monthly Component Acquisition Executive staff forums to provide guidance and share best practices. DHS has also strengthened its enterprise architecture program (or blueprint) to guide and constrain information technology acquisitions and has obtained a clean opinion on its financial statements for 2 consecutive years, fiscal years 2013 and 2014.
Improving and Modernizing Federal Disability Programs	The administration has set goals for hiring people with disabilities and launched a training course in July 2014 to help federal agencies hire, retain, and advance employees with disabilities. The administration continues to track—and has made some progress increasing—employment for people with disabilities at federal agencies.

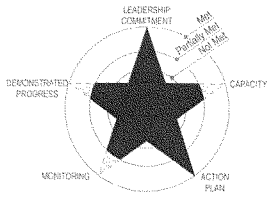
Source: GAO. | GAO-15-371T

Narrowing High Risk Areas

Since our 2013 update, sufficient progress has been made to narrow the scope of the following two areas.

Protecting Public Health through Enhanced Oversight of Medical Products

Protecting Public Health through Enhanced Oversight of Medical Products



TWO CRITERIA HAVE BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

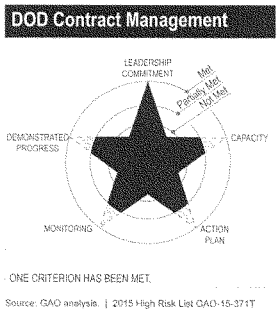
Our work has identified the following high-risk issues related to the Food and Drug Administration's (FDA) efforts to oversee medical products: (1) oversight of medical device recalls, (2) implementation of the Safe Medical Devices Act of 1990, (3) the effects of globalization on medical product safety, and (4) shortages of medically necessary drugs. We added the oversight of medical products to our High Risk List in 2009. Since our 2013 high-risk update, FDA has made substantial progress addressing the first two areas; therefore, we have narrowed this area to remove these issues from our High Risk List. However, the second two issues, globalization and drug shortages, remain pressing concerns.

FDA has greatly improved its oversight of medical device recalls by fully implementing all of the recommendations made in our 2011 report on this topic. Recalls provide an important tool to mitigate serious health consequences associated with defective or unsafe medical devices. We found that FDA had not routinely analyzed recall data to determine whether there are systemic problems underlying trends in device recalls. We made specific recommendations to the agency that it enhance its oversight of recalls. FDA is fully implementing our recommendations and has developed a detailed action plan to improve the recall process,

analyzed 10 years of medical device recall trend data, and established explicit criteria and set thresholds for determining whether recalling firms have performed effective corrections or removals of defective products. These actions have addressed this high-risk issue.

The Safe Medical Devices Act of 1990 requires FDA to determine the appropriate process for reviewing certain high-risk devices—either reclassifying certain high-risk medical device types to a lower-risk class or establishing a schedule for such devices to be reviewed through its most stringent premarket approval process. We found that FDA's progress was slow and that it had never established a timetable for its reclassification or re-review process. As a result, many high-risk devices—including device types that FDA has identified as implantable, life sustaining, or posing a significant risk to the health, safety, or welfare of a patient—still entered the market through FDA's less stringent premarket review process. We recommended that FDA expedite its implementation of the act. Since then, FDA has made good progress and began posting the status of its reviews on its website. FDA has developed an action plan with a goal of fully implementing the provisions of the act by the second quarter of calendar year 2015. While FDA has more work to do, it has made sufficient progress to address this high-risk issue.

DOD Contract Management



Source: GAO analysis. | 2015 High Risk List GAO-15-371T

Based on our reviews of DOD's contract management activities over many years, we placed this area on our High Risk List in 1992. For the past decade, our work and that of others has identified challenges DOD faces within four segments of contract management: (1) the acquisition workforce, (2) contracting techniques and approaches, (3) service acquisitions, and (4) operational contract support. DOD has made sufficient progress in one of the four segments—its management and oversight of contracting techniques and approaches—to warrant its removal as a separate segment within the overall DOD contract management high-risk area. Significant challenges still remain in the other three segments.

We made numerous recommendations to address the specific issues we identified. DOD leadership has generally taken actions to address our recommendations. For example, DOD promulgated regulations to better manage its use of time-and-materials contracts and undefinitized contract actions (which authorize contractors to begin work before reaching a final agreement on contract terms). In addition, OMB directed agencies to take action to reduce the use of noncompetitive and time-and-materials contracts. Similarly, Congress has enacted legislation to limit the length of

noncompetitive contracts and require DOD to issue guidance to link award fees to acquisition outcomes.

Over the past several years, DOD's top leadership has taken significant steps to plan and monitor progress in the management and oversight of contracting techniques and approaches. For example, through its Better Buying Power initiatives DOD leadership identified a number of actions to promote effective competition and to better utilize specific contracting techniques and approaches. In that regard, in 2010 DOD issued a policy containing new requirements for competed contracts that received only one offer—a situation OMB has noted deprives agencies of the ability to consider alternative solutions in a reasoned and structured manner and which DOD has termed "ineffective competition." These changes were codified in DOD's acquisition regulations in 2012. In May 2014, we concluded that DOD's regulations help decrease some of the risks of one offer awards, but also that DOD needed to take additional steps to continue to enhance competition, such as establishing guidance for when contracting officers should assess and document the reasons only one offer was received. DOD concurred with the two recommendations we made in our report and has since implemented one of them.

DOD also has been using its Business Senior Integration Group (BSIG)—an executive-level leadership forum—for providing oversight in the planning, execution, and implementation of these initiatives. In March 2014, the Director of the Office of Defense Procurement and Acquisition Policy presented an assessment of DOD competition trends that provided information on competition rates across DOD and for selected commands within each military department and proposed specific actions to improve competition. The BSIG forum provides a mechanism by which DOD can address ongoing and emerging weaknesses in contracting techniques and approaches and by which DOD can monitor the effectiveness of its efforts. Further, in June 2014, DOD issued its second annual assessment of the performance of the defense acquisition system. The assessment, included data on the system's competition rate and goals, assessments of the effect of contract type on cost and schedule control, and the impact of competition on the cost of major weapon systems.

An institution as large, complex, and diverse as DOD, and one that obligates hundreds of billions of dollars under contracts each year, will continue to face challenges with its contracting techniques and approaches. We will maintain our focus on identifying these challenges and proposing solutions. However, at this point DOD's continued commitment and demonstrated progress in this area—including the

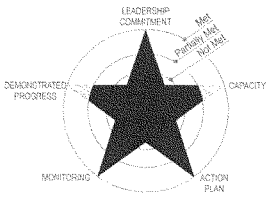
establishment of a framework by which DOD can address ongoing and emerging issues associated with the appropriate use of contracting techniques and approaches—provide a sufficient basis to remove this segment from the DOD contract management high-risk area.

Progress in Selected High-Risk Areas

In addition to the two areas that we narrowed—*Protecting Public Health through Enhanced Oversight of Medical Products* and *DOD Contract Management*—nine other areas met at least one of the criteria for removal from the High Risk List and were rated at least partially met for all four of the remaining criteria. These areas serve as examples of solid progress made to address high-risk issues through implementation of our recommendations and through targeted corrective actions. Further, each example underscores the importance of high-level attention given to high-risk areas within the context of our criteria by the administration and by congressional action. To sustain progress in these areas and to make progress in other high-risk areas—including eventual removal from the High Risk List—focused leadership attention and ongoing oversight will be needed.

NASA Acquisition Management

NASA Acquisition Management



THREE CRITERIA HAVE BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

The National Aeronautics and Space Administration's (NASA) acquisition management was included on the original High Risk List in 1990. NASA's continued efforts to strengthen and integrate its acquisition management functions have resulted in the agency meeting three criteria for removal from our High Risk List—leadership commitment, a corrective action plan, and monitoring. For example, NASA has completed the implementation of its corrective action plan, which was managed by the Deputy Administrator, with the Chief Engineer, the Chief Financial Officer, and the agency's Associate Administrator having led implementation of the individual initiatives.[6] The plan identified metrics to assess the progress of implementation, which NASA continues to track and report semi-annually. These metrics include cost and schedule performance indicators for NASA's major development projects. We have found that NASA's performance metrics generally reflect improved performance. For example, average cost and schedule growth for NASA's major projects has declined since 2011 and most of NASA's major projects are tracking metrics, which we recommended in 2011 to better assess design stability

[6]NASA's Associate Administrator oversees the agency's Office of Evaluation, which includes divisions responsible for cost analysis and independent program evaluation, respectively.

and decrease risk. In addition, NASA has taken action in response to our recommendations to improve the use of earned value management—a tool designed to help project managers monitor progress—such as by conducting a gap analysis to determine whether each center has the requisite skills to effectively utilize earned value management.

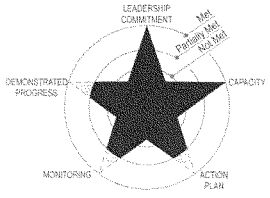
These actions have helped NASA to create better baseline estimates and track performance so that NASA has been able to launch more projects on time and within cost estimates. However, we found that NASA needs to continue its efforts to increase agency capacity to address ongoing issues through additional guidance and training of personnel. Such efforts should help maximize improvements and demonstrate that the improved cost and schedule performance will be sustained, even for the agency's most expensive and complex projects.

Recently, a few of NASA's major projects are rebaselining their cost, schedule, or both in light of management and technical issues, which is tempering the progress of the whole portfolio. In addition, several of NASA's largest and most complex projects, such as NASA's human spaceflight projects, are at critical points in implementation. We have reported on several challenges that may further impact NASA's ability to demonstrate progress in improving acquisition management[7].

[7] See *James Webb Space Telescope: Project Facing Increased Schedule Risk with Significant Work Remaining.* GAO-15-100. Washington, D.C.: December 15, 2014; *NASA: Actions Needed to Improve Transparency and Assess Long-Term Affordability of Human Exploration Programs.* GAO-14-385. Washington, D.C.: May 8, 2014; and *NASA: Assessments of Selected Large-Scale Projects.* GAO-14-338SP. Washington, D.C: April 15, 2014.

Establishing Effective Mechanisms for Sharing and Managing Terrorism-Related Information to Protect the Homeland

Establishing Effective Mechanisms for Sharing and Managing Terrorism-Related Information to Protect the Homeland



TWO CRITERIA HAVE BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

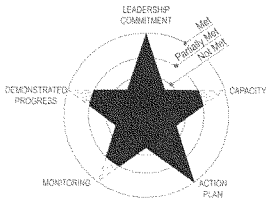
The federal government has made significant progress in promoting the sharing of information on terrorist threats since we added this issue to the High Risk List in 2003. As a result, the federal government has met our criteria for leadership commitment and capacity and has partially met the remaining criteria for this high-risk area. Significant progress was made in this area by developing a more structured approach to achieving the Information Sharing Environment (Environment) and by defining the highest priority initiatives to accomplish. In December 2012, the President released the National Strategy for Information Sharing and Safeguarding (Strategy), which provides guidance on the implementation of policies, standards, and technologies that promote secure and responsible national security information sharing. In 2013, in response to the Strategy, the Program Manager for the Environment released the Strategic Implementation Plan for the National Strategy for Information Sharing and Safeguarding (Implementation Plan).

The Implementation Plan provides a roadmap for the implementation of the priority objectives in the Strategy. The Implementation Plan also assigns stewards to coordinate each priority objective—in most cases, a senior department official—and provides time frames and milestones for achieving the outcomes in each objective. Adding to this progress is the work the Environment has done to address our previous recommendations. In our 2011 report on the Environment, we recommended that key departments better define incremental costs for information sharing activities and establish an enterprise architecture management plan. Since then, senior officials in each key department reported that any incremental costs related to implementing the Environment are now embedded within each department's mission activities and operations and do not require separate funding. Further, the 2013 Implementation Plan includes actions for developing aspects of an architecture for the Environment. In 2014, the program manager issued the Information Interoperability Framework, which begins to describe key elements intended to help link systems across departments to enable information sharing.

Going forward, in addition to maintaining leadership commitment and capacity, the program manager and key departments will need to continue working to address remaining action items informed by our five high-risk criteria, thereby helping to reduce risks and enhance the sharing and management of terrorism-related information.

Strengthening Department of Homeland Security Management Functions

Strengthening Department of Homeland Security Management Functions



TWO CRITERIA HAVE BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

The Department of Homeland Security (DHS) has continued efforts to strengthen and integrate its management functions since those issues were placed on the High Risk List in 2003. These efforts resulted in the department meeting two criteria for removal from the High Risk List (leadership commitment and a corrective action plan) and partially meeting the remaining three criteria (capacity, a framework to monitor progress, and demonstrated, sustained progress). DHS's top leadership, including the Secretary and Deputy Secretary of Homeland Security, have continued to demonstrate exemplary commitment and support for addressing the department's management challenges. For instance, the Department's Under Secretary for Management and other senior management officials have routinely met with us to discuss the department's plans and progress, which helps ensure a common understanding of the remaining work needed to address our high-risk designation.

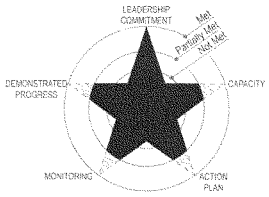
In April 2014, the Secretary of Homeland Security issued *Strengthening Departmental Unity of Effort*, a memorandum committing the agency to, among other things, improving DHS's planning, programming, budgeting, and execution processes through strengthened departmental structures and increased capability. In addition, DHS has continued to provide updates to the report *Integrated Strategy for High Risk Management*, demonstrating a continued focus on addressing its high-risk designation. The integrated strategy includes key management initiatives and related corrective action plans for achieving 30 actions and outcomes, which we identified and DHS agreed are critical to addressing the challenges within the department's management areas and to integrating those functions across the department. Further, DHS has demonstrated progress to fully address nine of these actions and outcomes, five of which it has sustained as fully implemented for at least 2 years. For example, DHS fully addressed two outcomes because it received a clean audit opinion on its financial statements for 2 consecutive fiscal years, 2013 and 2014. In addition, the department strengthened its enterprise architecture program (or technology blueprint) to guide IT acquisitions by, among other things, largely addressing our prior recommendations aimed at adding needed architectural depth and breadth.

DHS needs to continue implementing its *Integrated Strategy for High Risk Management* and show measurable, sustainable progress in implementing its key management initiatives and corrective actions and achieving outcomes. In doing so, it will be important for DHS to identify and work to mitigate any resource gaps, and prioritize initiatives as needed to ensure it can implement and sustain its corrective actions,

closely track and independently validate the effectiveness and sustainability of its corrective actions and make midcourse adjustments as needed; and make continued progress in achieving the 21 actions and outcomes it has not fully addressed, and demonstrate that systems, personnel, and policies are in place to ensure that progress can be sustained over time.

DOD Supply Chain Management

DOD Supply Chain Management



ONE CRITERION HAS BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

DOD supply chain management is one of the six issues that has been on the High Risk List since 1990. DOD has made progress in addressing weaknesses in all three dimensions of its supply chain management areas: inventory management, materiel distribution, and asset visibility. With respect to inventory management, DOD has demonstrated considerable progress in implementing its statutorily mandated corrective action plan. This plan is intended to reduce excess inventory and improve inventory management practices. Additionally, DOD has established a performance management framework, including metrics and milestones, to track the implementation and effectiveness of its corrective action plan and has demonstrated considerable progress in reducing its excess inventory and improving its inventory management. For example, DOD reported that its percentage of on-order excess inventory dropped from 9.5 percent in fiscal year 2009 to 7.9 percent in fiscal year 2013. DOD calculates the percentage by dividing the amount of on-order excess inventory by the total amount of on-order inventory. In response to our 2012 recommendations on the implementation of the plan, DOD continues to re-examine its goals for reducing excess inventory, has revised its goal for reducing on-hand excess inventory (it achieved its original goal early), and is in the process of institutionalizing its inventory management metrics in policy.

DOD has also made progress in addressing its materiel distribution challenges. Specifically, DOD has implemented, or is implementing, distribution-related initiatives that could serve as a basis for a corrective action plan. For example, DOD developed its Defense Logistics Agency Distribution Effectiveness Initiative, formerly called Strategic Network Optimization, to improve logistics efficiencies in DOD's distribution network and to reduce transportation costs. This initiative accomplishes these objectives by storing materiel at strategically located Defense Logistics Agency supply sites.

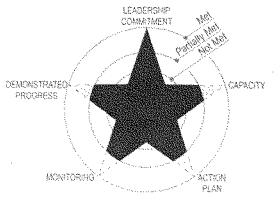
Further, DOD has demonstrated significant progress in addressing its asset visibility weaknesses by taking steps to implement our February 2013 recommendation that DOD develop a strategy and execution plans that contain all the elements of a comprehensive strategic plan, including,

among other elements, performance measures for gauging results. The National Defense Authorization Act for Fiscal Year 2014 required that DOD's strategy and implementation plans for asset visibility, which were in development, incorporate, among other things, the missing elements that we identified. DOD's January 2014 *Strategy for Improving DOD Asset Visibility* represents a corrective action plan and contains goals and objectives—as well as supporting execution plans—outlining specific objectives intended to improve asset visibility. DOD's *Strategy* calls for organizations to identify at least one outcome or key performance indicator for assessing performance in implementing the initiatives intended to improve asset visibility. DOD has also established a structure, including its Asset Visibility Working Group, for monitoring implementation of its asset visibility improvement initiatives.

Moving forward, the removal of DOD supply chain management from GAO's High Risk List will require DOD to take several steps. For inventory management, DOD needs to demonstrate sustained progress by continuing to reduce its on-order and on-hand excess inventory, developing corrective actions to improve demand forecast accuracy, and implementing methodologies to set inventory levels for reparable items (i.e., items that can be repaired) with low or highly variable demand. For materiel distribution, DOD needs to develop a corrective action plan that includes reliable metrics for, among other things, identifying gaps and measuring distribution performance across the entire distribution pipeline. For asset visibility, DOD needs to (1) specify the linkage between the goals and objectives in its Strategy and the initiatives intended to implement it and (2) refine, as appropriate, its metrics to ensure they assess progress towards achievement of those goals and objectives.

DOD Weapon Systems Acquisition

DOD Weapon Systems Acquisition



ONE CRITERION HAS BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

DOD weapon systems acquisition has also been on the High-Risk List since 1990. Congress and DOD have long sought to improve the acquisition of major weapon systems, yet many DOD programs are still falling short of cost, schedule, and performance expectations. The results are unanticipated cost overruns, reduced buying power, and in some cases delays or reductions in the capability ultimately delivered to the warfighter.

Our past work and prior high-risk updates have identified multiple weaknesses in the way DOD acquires the weapon systems it delivers to the warfighter and we have made numerous recommendations on how to address these weaknesses. Recent actions taken by top leadership at DOD indicate a firm commitment to improving the acquisition of weapon systems as demonstrated by the release and implementation of the Under Secretary of Defense for Acquisition, Technology, and Logistics' "Better Buying Power" initiatives. These initiatives include measures such as setting and enforcing affordability constraints, instituting a long-term investment plan for portfolios of weapon systems, implementing "should cost" management to control contract costs, eliminating redundancies within portfolios, and emphasizing the need to adequately grow and train the acquisition workforce.

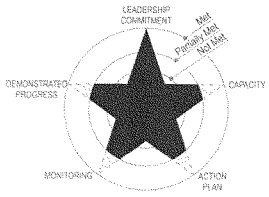
DOD also has made progress in its efforts to assess the root causes of poor weapon system acquisition outcomes and in monitoring the effectiveness of its actions to improve its management of weapon systems acquisition. Through changes to acquisition policies and procedures, DOD has made demonstrable progress and, if these reforms are fully implemented, acquisition outcomes should improve. At this point, there is a need to build on existing reforms by tackling the incentives that drive the process and behaviors. In addition, further progress must be made in applying best practices to the acquisition process, attracting and empowering acquisition personnel, reinforcing desirable principles at the beginning of the program, and improving the budget process to allow better alignment of programs and their risks and needs. While DOD has made real progress on the issues we have identified in this area, with the prospect of slowly growing or flat defense budgets for years to come, the department must continue this progress and get better returns on its weapon system investments than it has in the past.

DOD has made some progress in updating its policies to enable better weapon systems outcomes. However, even with this call for change we remain concerned about the full implementation of proposed reforms as DOD has, in the past, failed to convert policy into practice. In addition,

although we reported in March 2014 on the progress many DOD programs are making in reducing their cost in the near term, individual weapon programs are still failing to conform to best practices for acquisition or to implement key acquisition reforms and initiatives that could prevent long-term cost and schedule growth.[8]

Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting the Privacy of Personally Identifiable Information

Ensuring the Security of Federal Information Systems and Cyber Critical Infrastructure and Protecting the Privacy of Personally Identifiable Information



ONE CRITERION HAS BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

We added this high-risk area in 1997 and expanded it this year to include protection of PII. Although significant challenges remain, the federal government has made progress toward improving the security of its cyber assets. For example, Congress, as part of its ongoing oversight, passed five bills, which became law, for improving the security of cyber assets. The first, The Federal Information Security Modernization Act of 2014,[9] revises the Federal Information Security Management Act of 2002[10] and clarifies roles and responsibilities for overseeing and implementing federal agencies' information security programs. The second law, the Cybersecurity Workforce Assessment Act,[11] requires DHS to assess its cybersecurity workforce and develop a strategy for addressing workforce gaps. The third, the Homeland Security Cybersecurity Workforce Assessment Act,[12] requires DHS to identify all of its cybersecurity positions and calls for the department to identify specialty areas of critical need in its cybersecurity workforce. The fourth, the National Cybersecurity Protection Act of 2014,[13] codifies the role of DHS' National Cybersecurity and Communications Integration Center as the nexus of cyber and communications integration for the federal government, intelligence community, and law enforcement. The fifth, the Cybersecurity Enhancement Act of 2014,[14] authorizes the Department of Commerce, through the National Institute of Standards and Technology, to facilitate and support the development of voluntary standards to reduce cyber risks to critical infrastructure.

[8]GAO, *Defense Acquisitions: Assessments of Selected Weapon Programs*, GAO-14-340SP (Washington, D.C.: Mar. 31, 2014).

[9]Pub. L. No. 113-283 (Dec. 18, 2014).

[10]Title III, E-Government Act of 2002, Pub. L. No. 107-347 (Dec. 17, 2002).

[11]Pub. L. No. 113-246 (Dec. 18, 2014).

[12]Sec. 4, Pub. L. No. 113-277 (Dec. 18, 2014).

[13]Pub. L. No. 113-282 (Dec. 18, 2014).

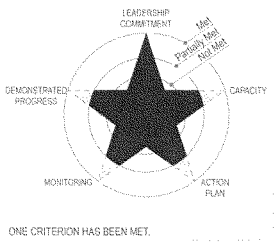
[14]Pub. L. No. 113-274 (Dec. 18, 2014).

The White House and senior leaders at DHS have also committed to securing critical cyber assets. Specifically, the President has signed legislation and issued strategy documents for improving aspects of cybersecurity, as well as an executive order and a policy directive for improving the security and resilience of critical cyber infrastructure. In addition, DHS and its senior leaders have committed time and resources to advancing cybersecurity efforts at federal agencies and to promoting critical infrastructure sectors' use of a cybersecurity framework.

However, securing cyber assets remains a challenge for federal agencies. Continuing challenges, such as shortages in qualified cybersecurity personnel and effective monitoring of, and continued weaknesses in, agencies' information security programs need to be addressed.

Until the White House and executive branch agencies implement the hundreds of recommendations that we and agency inspectors general have made to address cyber challenges, resolve identified deficiencies, and fully implement effective security programs and privacy practices, a broad array of federal assets and operations may remain at risk of fraud, misuse, and disruption, and the nation's most critical federal and private sector infrastructure systems will remain at increased risk of attack from adversaries. In addition to the recently passed laws addressing cybersecurity and the protection of critical infrastructures, Congress should also consider amending applicable laws, such as the Privacy Act and E-Government Act, to more fully protect PII collected, used, and maintained by the federal government.

Management of Federal Oil and Gas Resources



Source: GAO analysis. | 2015 High Risk List GAO-15-371T

The Department of the Interior's (Interior) continued efforts to improve its management of federal oil and gas resources since we placed these issues on the High Risk List in 2011 have resulted in the department meeting one of the criteria for removal from our High Risk List—leadership commitment. Interior has implemented a number of strategies and corrective measures to help ensure the department collects its share of revenue from oil and gas produced on federal lands and waters. Additionally, Interior is developing a comprehensive approach to address its ongoing human capital challenges. In November 2014, Interior senior leaders briefed us on the department's commitment to address the high-risk issue area by describing the following corrective actions.

- To help ensure Interior collects revenues from oil and gas produced on federal lands and waters, Interior has taken steps to strengthen its efforts to improve the measurement of oil and gas produced on federal leases by ensuring a link between what happens in the field (measurement and operations) and what is reported to Interior's Office of Natural Resources Revenue or ONRR (production volumes and dispositions). To ensure that federal oil and gas leases are inspected, Interior is hiring inspectors and engineers with an understanding of metering equipment and measurement accuracy. The department has several efforts under way to assure that oil and gas are accurately measured and reported. For example, ONRR contracted for a study to automate data collection from production metering systems. In 2012, the Bureau of Safety and Environmental Enforcement hired and provided measurement training to a new measurement inspection team. To better ensure a fair return to the federal government from leasing and production activities from federal offshore leases, Interior raised royalty rates, minimum bids, and rental rates. For onshore federal leases, according to Interior's November 2014 briefing document, ONRR's Economic Analysis Office will provide the Bureau of Land Management (BLM) monthly analyses of global and domestic market conditions as BLM initiates a rulemaking effort to provide greater flexibility in setting onshore royalty rates.
- To address the department's ongoing human capital challenges, Interior is working with the Office of Personnel Management to establish permanent special pay rates for critical energy occupations in key regions, such as the Gulf of Mexico. Bureau managers are being trained on the use of recruitment, relocation, and retention incentives to improve hiring and retention. Bureaus are implementing or have implemented data systems to support the accurate capture of hiring data to address delays in the hiring process. Finally, Interior is

developing strategic workforce plans to assess the critical skills and competencies needed to achieve current and future program goals.

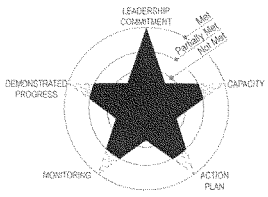
To address its revenue collection challenges, Interior will need to identify the staffing resources necessary to consistently meet its annual goals for oil and gas production verification inspections. Interior needs to continue meeting its time frames for updating regulations related to oil and gas measurement and onshore royalty rates. It will also need to provide reasonable assurance that oil and gas produced from federal leases is accurately measured and that the federal government is getting an appropriate share of oil and gas revenues.

To address its human capital challenges, Interior needs to consider how it will address staffing shortfalls over time in view of continuing hiring and retention challenges. It will also need to implement its plans to hire additional staff with expertise in inspections and engineering. Interior needs to ensure that it collects and maintains complete and accurate data on hiring times—such as the time required to prepare a job description, announce the vacancy, create a list of qualified candidates, conduct interviews, and perform background and security checks—to effectively implement changes to expedite its hiring process.

Medicare Improper Payments

Medicare Program

Medicare improper payments



ONE CRITERION HAS BEEN MET.

Source: GAO analysis. | 2015 High Risk List GAO-15-371T

The Centers for Medicare & Medicaid Services (CMS), in the Department of Health and Human Services (HHS), administers Medicare, which has been on the High Risk List since 1990.[15] CMS has continued to focus on reducing improper payments in the Medicare program, which has resulted in the agency meeting our leadership commitment criterion for removal from the High Risk List and partially meeting our other four criteria. HHS has demonstrated top leadership support for addressing this risk area by continuing to designate "strengthened program integrity through improper payment reduction and fighting fraud" an HHS strategic priority and, through its dedicated Center for Program Integrity, CMS has taken multiple actions to improve in this area. For example, as we recommended in November 2012, CMS centralized the development and implementation of automated edits—prepayment controls used to deny Medicare claims that should not be paid—based on a type of national

[15]The Medicare program has been on the High Risk List since 1990 but given the importance of sustained Medicare integrity to protecting federal dollars, we are focusing this high-risk rating and assessment on CMS's efforts to reduce Medicare improper payments.

policy called national coverage determinations. Such action will ensure greater consistency in paying only those Medicare claims that are consistent with national policies.

In addition, CMS has taken action to implement provisions of the Patient Protection and Affordable Care Act that Congress enacted to combat fraud, waste, and abuse in Medicare. For instance, in March 2014, CMS awarded a contract to a Federal Bureau of Investigation-approved contractor that will enable the agency to conduct fingerprint-based criminal history checks of high-risk providers and suppliers. This and other provider screening procedures will help block the enrollment of entities intent on committing fraud.

CMS made positive strides, but more needs to be done to fully meet our criteria. For example, CMS has demonstrated leadership commitment by taking actions such as strengthening provider and supplier enrollment provisions, and improving its prepayment and postpayment claims review process in the fee-for-service (FFS) program.[16] However, all parts of the Medicare program are on the Office of Management and Budget's list of high-error programs, suggesting additional actions are needed. By implementing our open recommendations, CMS may be able to reduce improper payments and make progress toward fulfilling the four outstanding criteria to remove Medicare improper payments from our High Risk List. The following summarizes open recommendations and procedures authorized by the Patient Protection and Affordable Care Act that CMS should implement to make progress toward fulfilling the four outstanding criteria to remove Medicare improper payments from our High Risk List. CMS should

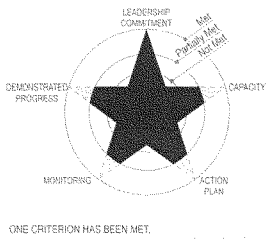
- require a surety bond for certain types of at-risk providers and suppliers;
- publish a proposed rule for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, such as whether the provider or supplier has

[16]Medicare consists of four parts. Parts A and B are known as Medicare FFS. Part A covers hospital and other inpatient stays and Part B covers hospital outpatient, physician, and other services. Part C, also known as Medicare Advantage, is the private plan alternative to Medicare FFS under which beneficiaries receive benefits through private health plans. Part D is the outpatient prescription drug benefit.

been subject to a payment suspension from a federal health care program;

- establish core elements of compliance programs for providers and suppliers;
- improve automated edits that identify services billed in medically unlikely amounts;
- develop performance measures for the Zone Program Integrity Contractors who explicitly link their work to the agency's Medicare FFS program integrity performance measures and improper payment reduction goals;
- reduce differences between contractor postpayment review requirements, when possible;
- monitor the database used to track Recovery Auditors' activities to ensure that all postpayment review contractors are submitting required data and that the data the database contains are accurate and complete;
- require Medicare administrative contractors to share information about the underlying policies and savings related to their most effective edits; and
- efficiently and cost-effectively identify, design, develop, and implement an information technology solution that addresses the removal of Social Security numbers from Medicare beneficiaries' health insurance cards.

Mitigating Gaps in Weather Satellite Data



Source: GAO analysis. | 2015 High Risk List GAO-15-371T

The National Oceanic and Atmospheric Administration (NOAA) has made progress toward improving its ability to mitigate gaps in weather satellite data since the issue was placed on the High Risk List in 2013. NOAA has demonstrated leadership on both its polar-orbiting and geostationary satellite programs by making decisions on how it plans to mitigate anticipated and potential gaps, and in making progress on multiple mitigation-related activities. In addition, the agency implemented our recommendations to improve its polar-orbiting and geostationary satellite gap contingency plans. Specifically, in September 2013, we recommended that NOAA establish a comprehensive contingency plan for potential polar satellite data gaps that was consistent with contingency planning best practices. In February 2014, NOAA issued an updated plan that addressed many, but not all, of the best practices. For example, the updated plan includes additional contingency alternatives; accounts for additional gap scenarios; identifies mitigation strategies to be executed; and identifies specific activities for implementing those strategies along with associated roles and responsibilities, triggers, and deadlines.

In addition, in September 2013, we reported that while NOAA had established contingency plans for the loss of geostationary satellites, these plans did not address user concerns over potential reductions in capability and did not identify alternative solutions and timelines for preventing a delay in the Geostationary Operational Environmental Satellite-R (GOES-R) launch date. We recommended the agency revise its contingency plans to address these weaknesses. In February 2014, NOAA released a new satellite contingency plan that improved in many, but not all, of the best practices. For example, the updated plan clarified requirements for notifying users regarding outages and impacts and provided detailed information on responsibilities for each action in the plan.

NOAA has demonstrated leadership commitment in addressing data gaps of its polar-orbiting and geostationary weather satellites by making decisions about how to mitigate potential gaps and by making progress in implementing multiple mitigation activities. However, capacity concerns—including computing resources needed for some polar satellite mitigation activities and the limited time available for integration and testing prior to the scheduled launch of the next geostationary satellite—continue to present challenges. In addition, while both programs have updated their satellite contingency plans, work remains to implement and oversee efforts to ensure that mitigation plans will be viable if and when they are needed.

Sustaining Attention on High-Risk Programs

Overall, the government continues to take high-risk problems seriously and is making long-needed progress toward correcting them. Congress has acted to address several individual high-risk areas through hearings and legislation. Our high-risk update and high-risk website, http://www.gao.gov/highrisk/, can help inform the oversight agenda for the 114th Congress and guide efforts of the administration and agencies to improve government performance and reduce waste and risks. In support of Congress and to further progress to address high-risk issues, we continue to review efforts and make recommendations to address high-risk areas. Continued perseverance in addressing high-risk areas will ultimately yield significant benefits.

Thank you, Chairman Johnson, Ranking Member Carper, and Members of the Committee. This concludes my testimony. I would be pleased to answer any questions.

For further information on this testimony, please contact J. Christopher Mihm at (202) 512-6806 or mihmj@gao.gov. Contact points for the individual high-risk areas are listed in the report and on our high-risk web site. Contact points for our Congressional Relations and Public Affairs offices may be found on the last page of this statement.

United States Government Accountability Office

GAO

Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

November 2014

VA HEALTH CARE

Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data

GAO-15-55

GAO Highlights

Highlights of GAO-15-55, a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

November 2014

VA HEALTH CARE

Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data

Why GAO Did This Study

In 2013, VA estimated that about 1.5 million veterans required mental health care, including services for MDD. MDD is a debilitating mental illness related to reduced quality of life and productivity, and increased risk for suicide. VA also plays a role in suicide prevention. GAO was asked to review how VA tracks veterans prescribed antidepressants and what suicide data VA uses in its prevention efforts.

This report examines (1) VA's data on veterans with MDD, including those prescribed an antidepressant; (2) the extent that veterans with MDD who are prescribed antidepressants receive recommended care and the extent to which VA monitors such care; and (3) the quality of data VA requires VAMCs to collect on veteran suicides. GAO analyzed VA data, interviewed VA officials, and conducted site visits to six VAMCs selected based on geography and population served. From each of these six VAMCs, GAO also reviewed five randomly selected medical records for veterans diagnosed with MDD and prescribed an antidepressant in 2012, as well as all completed BHAP templates. The results cannot be generalized across VA but provide insights.

What GAO Recommends

GAO recommends that VA identify and address MDD coding discrepancies; implement processes to review data and assess deviations from recommended care; and implement processes to improve completeness, accuracy, and consistency of veteran suicide data. VA concurred with GAO's recommendations and described its plans to implement them.

View GAO-15-55. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

What GAO Found

GAO's analysis of Department of Veterans Affairs (VA) data for fiscal years 2009 through 2013 shows that about 10 percent of veterans who received VA health care services were diagnosed with major depressive disorder (MDD). MDD is characterized by depressed mood or loss of interest along with other symptoms for 2 weeks or more that represent a change in the way individuals function from their previous behaviors. Because GAO found diagnostic coding discrepancies in 11 of the 30 veterans' medical records it reviewed from six VA medical centers (VAMC), VA's data may understate the prevalence of MDD among veterans being treated through VA, to the extent that such discrepancies may permeate VA's data. One treatment for MDD is the use of medications such as antidepressants. According to GAO's analysis, 94 percent of veterans diagnosed with MDD were prescribed at least one antidepressant.

VA policy states that antidepressant treatment must be consistent with VA's current clinical practice guideline (CPG); however, GAO's review of 30 veterans' medical records identified deviations from selected MDD CPG recommendations for most veterans reviewed. For example, 26 of the 30 veterans were not assessed using a standardized assessment tool at 4 to 6 weeks after initiation of treatment, as recommended in the CPG. Additionally, 10 veterans did not receive follow up within the time frame recommended in the CPG. GAO found that VA does not have a system-wide process in place to identify and fully assess whether the care provided is consistent with the CPG. As a result, VA does not know the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG and whether appropriate actions are taken by VAMCs to mitigate potentially significant risks to veterans.

The demographic and clinical data that VA collects on veteran suicides were not always complete, accurate, or consistent. VA's Behavioral Health Autopsy Program (BHAP) is a quality initiative to improve VA's suicide prevention efforts by identifying information that VA can use to develop policy and procedures to help prevent future suicides. The BHAP templates are a mechanism by which VA collects suicide data from VAMC's review of veteran medical records. GAO's review of 63 BHAP templates at five VAMCs found that 40 of the templates that VAMCs submitted to VA Central Office had incomplete data. Also, GAO found that the BHAP templates VAMCs submitted contained inaccurate data. For example, 6 BHAP templates included a date of death that was incorrect based on information in the veteran's medical record, and 9 BHAP templates included an incorrect number of outpatient VA mental health visits in the last 30 days. Moreover, GAO found that VAMCs submitted inconsistent information because they interpreted VA's guidance on completing the BHAP templates differently. This situation was further exacerbated because BHAP templates prepared by VAMCs are generally not being reviewed at any level within the Department for completeness, accuracy, and consistency. Lack of complete, accurate, and consistent data and poor oversight can inhibit VA's ability to identify, evaluate, and improve ways to better inform its suicide prevention efforts.

Contents

Figures

Abbreviations

BHAP	Behavioral Health Autopsy Program
BHL	Behavioral Health Laboratory
CPG	clinical practice guideline
DOD	Department of Defense
Handbook	*Uniform Mental Health Services in VA Medical Centers and Clinics* handbook
MDD	major depressive disorder
OIG	Office of Inspector General
OMHO	Office of Mental Health Operations
OMHS	Office of Mental Health Services
PHQ	Patient Health Questionnaire
SPAN	Suicide Prevention Application Network
TIDES	Translating Initiatives for Depression into Effective Solutions
VA	Department of Veterans Affairs
VAMC	Veterans Affairs medical center
VISN	Veterans Integrated Service Network

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

November 12, 2014

The Honorable Mike Coffman
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

In 2013, the Department of Veterans Affairs (VA) estimated that about 1.5 million veterans required mental health services, which VA provides in a variety of settings, including VA medical centers (VAMC), community-based outpatient clinics, and residential treatment programs.[1] Mental health treatment includes services for depression—a mood disorder that causes a persistent feeling of sadness and loss of interest. One type of depression, major depressive disorder (MDD), is a particularly debilitating mental illness and is associated with reduced quality of life, reduced productivity, and increased risk for suicide. These negative effects underscore the importance of timely, evidence-based assessment for and treatment of MDD, which may include medications, such as antidepressants, psychotherapy, or a combination of both. Treatment of veterans with MDD can improve their occupational and social functioning and their overall well-being.

In addition to providing ongoing care to veterans with MDD, VA plays a role in suicide risk assessment and prevention among veterans. According to VA, about one-quarter of the 18 to 22 veterans who die by suicide each day were receiving care through VA.[2] Research has identified numerous risk factors for suicide among veterans, which include substance use disorder, physical impairments, previous suicide attempts, and depression. Additionally, life stressors, such as marital or financial problems, contribute to a veteran's risk of suicide.

[1]For purposes of this report, references to VAMCs include the associated community-based outpatient clinics.

[2]VA/Department of Defense (DOD) Assessment and Management of Risk for Suicide Working Group, *VA/DOD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide* (June 2013).

Given the debilitating effects of depression, VA's monitoring of veterans with MDD is critical to ensuring positive health outcomes. Additionally, the relatively high veteran suicide rate makes it important that VA effectively employs data related to suicides in its prevention efforts. You asked us to review how VA tracks and manages veterans prescribed antidepressants and what suicide data VA uses in its suicide prevention efforts. In this report, we examine

1. the data VA has on veterans with MDD, including the extent to which they were prescribed antidepressants;
2. the extent to which veterans with MDD who are prescribed an antidepressant receive recommended care and the extent to which VA monitors such care; and
3. the information VA requires VAMCs to collect on veteran suicides.

To examine the data VA has on veterans with MDD, including the extent to which veterans were prescribed antidepressants, we analyzed national VA data from fiscal years 2009 through 2013 and interviewed VA officials.[3] The data we analyzed included information on veterans' demographic characteristics, health care services, and medications provided through VA.[4] We considered a veteran to have MDD if, in at least one fiscal year included in our review, the veteran had two or more outpatient encounters or at least one inpatient hospital stay associated with a diagnosis of MDD.[5] To ensure the reliability of the data we analyzed, we interviewed VA Central Office officials, reviewed relevant documentation and veterans' medical records, and conducted electronic

[3]Data on whether veterans served during recent conflicts in Iraq and Afghanistan came from DOD.

[4]The data include health care services and medications provided by non-VA providers but paid for by VA through its Non-VA Medical Care Program, formerly known as the Fee Basis Program. Non-VA medical care is the practice of paying for veterans' health care services outside of VA when VA medical facilities are not feasibly available.

[5]The definition of MDD as defined in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* was effective for a majority of the time period that our study covers. According to the American Psychiatric Association, the core symptoms and duration of these symptoms to meet the definition of MDD have not changed from the fourth to fifth edition of the manual. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision (DSM-IV-TR) (Washington, D.C.: American Psychiatric Association, 2000).

testing to identify missing data and obvious errors.[6] On the basis of these activities, we determined that the data we analyzed were sufficiently reliable for our purposes. We also conducted site visits to 6 of the 150 VAMCs selected for variation in complexity of health care services offered, geographic location, and number of veterans using mental health services. These six VAMCs were located in Canandaigua, New York; Gainesville, Florida; Iowa City, Iowa; Philadelphia, Pennsylvania; Phoenix, Arizona; and Reno, Nevada.[7] At each site, we interviewed VAMC staff about the data maintained on veterans diagnosed with MDD. In addition, we reviewed a random, nongeneralizeable sample of medical records for five veterans treated at each of the six VAMCs for a total of 30 veterans. We selected veterans for review that were diagnosed with MDD and had a new treatment episode of an antidepressant in calendar year 2012. Starting with the initial encounter in 2012 that was associated with the new antidepressant prescription, we reviewed the medical records to determine if the diagnostic code entered for subsequent encounters was consistent with a diagnosis of MDD.

To analyze the extent to which VA monitors whether veterans with MDD who are prescribed an antidepressant receive care as recommended by VA's clinical practice guideline (CPG) for MDD, we reviewed VA policy documents and interviewed VA Central Office officials responsible for developing and implementing VA mental health policy.[8] We identified the oversight processes VA has in place to monitor the recommendations in the CPG and assessed whether this oversight provides VA with adequate information to identify nonconformance with recommended practices, assess the risk, and address nonconformance, as appropriate. We selected three CPG recommendations for inclusion in our review that had

[6]Throughout the report, we use the phrase medical records to refer to electronic medical records.

[7]In contrast to the other site visits, which were completed in person, we completed the site visits to the VAMCs located in Gainesville, Florida, and Reno, Nevada, virtually through telephone interviews.

[8]The MDD CPG is formally known as the *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder* (May, 2009). The MDD CPG was issued by the joint VA/DOD Evidence-Based Practice Work Group in 2009. Formed in 1999 and composed of VA and DOD officials, the VA/DOD Evidence-Based Practice Work Group makes decisions about which CPGs for specific conditions will be developed and oversees their development. VA's Office of Mental Health Services is responsible for developing mental health policy and the Office of Mental Health Operations (OMHO) is responsible for implementing these policies.

among the highest strength of research evidence, were sufficiently specific to enable us to determine the extent to which VA providers were following the recommendation, and would not require clinical judgment to determine the extent to which VA providers were following the recommendation.[9] To examine how the recommendations we selected were implemented, we reviewed the 30 medical records from our selected six VAMCs to assess the extent to which the antidepressant treatment-related care VAMCs provided was consistent with the CPG recommendations. We also interviewed VAMC officials regarding the care provided to veterans with MDD prescribed an antidepressant. Results from our 30 medical record reviews cannot be generalized to the VAMC visited or other VAMCs.

To analyze the information VA requires VAMCs to collect on veteran suicides, we reviewed VA policies, guidance, and documents related to VA's suicide prevention efforts to identify the data collected by VA staff on veteran suicides. We also interviewed VA Central Office and other officials responsible for VA's suicide prevention program. Additionally, through the site visits to six VAMCs, we obtained documents and interviewed officials regarding the collection of veteran suicide data and suicide prevention initiatives. We compared 63 data templates related to veteran suicides completed by VAMC staff as of the date of our site visits—or the date of our request for virtual site visits—to information included in the veterans' medical records and to templates we received from VA Central Office.[10] We identified fields in the documents to review based on whether the field related to aspects of VA treatment—including treatment for mental health conditions—and the date of the veteran's death. We identified these fields because they did not require clinical

[9]The three recommendations related to monitoring veterans prescribed antidepressants from the CPG that we judgmentally selected were (1) to enhance antidepressant treatment, veterans should be educated on when to take the medication, possible side effects, risks, and the expected duration of treatment; (2) standardized assessments of depressive symptoms should be used to monitor treatment response at 4-6 weeks after initiation of treatment, after each change in treatment, and periodically thereafter until full remission is achieved; and (3) a plan should be developed that addresses the duration of antidepressant treatment.

[10]The Behavioral Health Autopsy Program (BHAP) Post-Mortem Chart Analysis Template (BHAP template) is a mechanism by which VA Central Office collects veteran suicide data from VAMCs' review of veterans' medical records. One BHAP template had been completed as of the time of our site visit, but had not been received by VA Central Office; therefore, we did not include this template in our review.

judgment to assess. Results from our review of veteran suicide data can be generalized to the VAMCs we visited, but cannot be generalized to other VAMCs. We also interviewed relevant staff of the six Veterans Integrated Service Networks (VISN), or regional networks of care, for the sites we visited to obtain information on suicide prevention efforts in that VISN.[11]

For more information on our scope and methodology, see appendix I.

We conducted this performance audit from November 2013 to November 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

VA provides care to veterans with mental health needs through its 150 VAMCs, which may include both specialty mental health care settings—including mental health clinics—and other settings that may provide mental health services but focus primarily on other types of care, such as primary care. VA has implemented a program to co-locate mental health care providers within primary care settings in an effort to promote effective treatment of common mental health conditions in the primary care environment while allowing mental health specialists to focus on veterans with more severe mental illnesses.

Care for Veterans with MDD

According to VA, the prevalence of MDD in primary care settings among veterans being treated through VA is higher than that among the general population. MDD is characterized by the presence of depressed mood or loss of interest or pleasure along with other symptoms for a period of at

[11]Each VAMC is assigned to a single VISN.

least 2 weeks that represent a change in previous functioning.[12] VA has policies and guidance in place related to treating veterans with MDD. For example, the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook (Handbook), which defines VA's minimum clinical requirements for mental health services, requires that VA facilities provide evidence-based treatment through the administration of medication, when indicated, consistent with the MDD CPG.[13] The CPG is guidance intended by VA to reduce current practice variation between clinicians and provide facilities with a structured framework to help improve patient outcomes.[14]

The MDD CPG provides evidence-based recommendations as guidance for clinicians who provide care for veterans with MDD.[15] The MDD CPG includes approximately 200 recommendations to provide information and assist in decision making for clinicians who provide care for adults with MDD.[16] For example, the CPG recommends that standardized assessments of depressive symptoms, such as the nine item Patient Health Questionnaire (PHQ-9), should be used at the initial assessment of MDD symptoms, to monitor treatment response at 4-6 weeks after initiation of treatment, after each change in treatment, and periodically

[12]These symptoms include significant weight loss; insomnia or excessive sleeping; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive or inappropriate guilt; diminished ability to think or concentrate, or indecisiveness; and recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Arlington, VA: American Psychiatric Association, 2013).

[13]Veterans Health Administration Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008). The Handbook also requires that VAMCs provide evidence-based psychotherapy, such as Cognitive Behavioral Therapy, to veterans when appropriate. However, these services fall outside the scope of our review.

[14]The CPG also states that it is intended to "identify outcome measures to support the development of practice-based evidence that can ultimately be used to improve the clinical guidelines."

[15]The CPG is based on a review of research outcomes available at the time of publication. Evidence-based care refers to approaches that have consistently been shown in controlled research to be effective for a particular condition or conditions.

[16]The CPG for MDD is organized into 22 main topics, such as "initial treatment" and "treatment response." Each main topic contains a number of action statements that relate to approximately 200 recommendations for the management of veterans with MDD.

thereafter until full remission is achieved.[17] Evidence shows that follow-up assessment is effective 4-6 weeks after initiation of treatment, making timely follow-up visits an important part of clinicians' ability to assess whether the current treatment plan is effective or should be modified. According to the MDD CPG, veterans with MDD treated with antidepressants should be closely observed, particularly at the beginning of treatment and following dosage changes, to maximize veterans' recovery and to mitigate any negative treatment effects, including worsening of depressive symptoms. The CPG should not take the place of the clinician's clinical judgment.

VA Suicide Prevention Efforts

Beginning in June 2006, VA implemented several initiatives aimed at suicide prevention, including appointing a National Suicide Prevention Coordinator, developing data systems to increase understanding of suicide among veterans and inform VA suicide prevention programs, and instituting suicide prevention programs in VAMCs throughout the country. Additionally, VA Central Office established the Center of Excellence for Suicide Prevention and the Veterans Crisis Line in 2007. The Center of Excellence collects VA suicide prevention program data, which provides information on veteran suicide completions and suicide attempts for veterans receiving VA care, as well as those veterans not receiving VA care. VA's Veterans Crisis Line provides toll-free, confidential support 24 hours per day for veterans, their families, and their friends through phone, online chat, or text message.[18] In fiscal year 2013, the Veterans Crisis Line fielded approximately 287,000 calls, 54,800 online chats, and 11,300 text messages.

As part of VAMCs' suicide prevention programs, the Handbook requires each VAMC to have a suicide prevention coordinator whose responsibilities include

- establishing and maintaining a list of veterans assessed to be at high risk for suicide;

[17]The PHQ-9 is a diagnostic tool, which uses the nine MDD diagnosis symptoms as criteria to help clinicians make a criteria-based diagnosis of depressive disorders and measure depression severity to aid treatment decisions.

[18]The Veterans Crisis line can be reached by calling 1-800-273-8255 and pressing 1, online at www.VeteransCrisisLine.net, or sending a text message to 838255.

- monitoring these high-risk veterans;
- responding to referrals from staff and the Veterans Crisis Line;
- collaborating with community organizations and partners;
- training staff members who have contact with veterans at the VAMC, community organizations, and partners; and
- collecting and reporting information on veterans who die by suicide and who attempt suicide.

See appendix II for more information on VAMCs' tracking of veterans at high risk for suicide.

VA Suicide Data

VA Central Office uses several mechanisms to collect data on veteran suicides to help improve its suicide prevention efforts. One such mechanism includes data submitted by suicide prevention coordinators at VAMCs on known veterans who die by suicide.[19] Beginning in December 2012, VA Central Office began a national initiative to collect demographic, clinical, and other related information on veteran suicides as a quality improvement initiative to improve its suicide prevention efforts by identifying information that can be used by VA Central Office to develop policy and procedures to help prevent future veteran deaths.[20] This initiative, the Behavioral Health Autopsy Program (BHAP), replaced previous VA Central Office requirements to collect data on completed suicides.[21] VA Central Office officials explained that they transitioned to the BHAP initiative to collect more systematic and comprehensive information about suicides, to incorporate interviews of family members of those who die by suicide, and to collect more contextual information.

[19]Veteran suicide data is submitted by VAMCs to VA's Center of Excellence for Suicide Prevention located in VISN 2. The Center of Excellence was created by VA Central Office, and for the purposes of our report, we refer to the Center of Excellence as part of VA Central Office.

[20]As part of this initiative, VA collects veterans' demographic data, such as date of birth, date of death, race, ethnicity, and gender. VA also collects clinical data, such as the date of the veteran's final VA visit, whether the final visit was outpatient or inpatient, and the results of mental health screens, including depression screens.

[21]Prior to BHAPs, VA Central Office required suicide prevention coordinators to complete a review for suicide completions and attempts that identified, for example, the contributing factors for the event. Suicide prevention coordinators would then complete an aggregate analysis of all reported veteran suicides.

According to VA, the BHAP quality initiative has been adapted from a traditional psychological autopsy research framework that emphasizes the importance of information from outside sources as well as from those within the health care setting. The BHAP initiative is being implemented by VA in four phases:

- **Phase 1—Standardized chart reviews**: VAMCs' suicide prevention coordinators are required to complete standardized chart reviews for all veterans' suicides known to VAMC staff and reported on or after October 1, 2012.[22] These reviews include specific information on a veteran's utilization of VA health care services, as well as a veteran's mental health diagnoses and risk factors for suicide. VA Central Office has instructed suicide prevention coordinators to use all available information, including VA medical records and information from a veteran's family members to complete the chart review. These reviews are submitted to VA Central Office through completion of a BHAP Post-Mortem Chart Analysis Template (BHAP template) and VA Central Office has provided suicide prevention coordinators with a BHAP Guide on how to complete the fields in the BHAP template. VA Central Office requires VAMCs to submit the BHAP template within 30 days of VAMC staff becoming aware of a veteran's death by suicide.
- **Phase 2—Interviews with family members**: In fiscal year 2013, VA Central Office began conducting interviews with family members of veterans who have died by suicide to obtain information on suicide risks, barriers to care, and suggestions for new programs to prevent suicide.[23]

[22]VAMCs can also submit reviews for veterans who did not utilize VA health care services. Veterans not being seen within the VA will not have clinical information available in VA's medical records, but VAMCs can report information that is known through other mechanisms, such as a coroner's report or the veteran's family members, if available. According to VA, a comprehensive suicide prevention program requires timely and accurate information beyond that acquired from veterans being seen in VA. Data on these veterans are needed to, among other things, improve understanding of suicide among all veterans.

[23]Suicide prevention coordinators are responsible for asking family members if they are interested in participating in an interview. According to VA Central Office officials, a social worker at VA's Center of Excellence for Suicide Prevention conducts the family interview and multiple participants may be included in the interview.

- **Phase 3—Clinician questionnaire**: This phase, which has not yet been implemented, will include an interview with the last provider that saw the veteran prior to his or her death. VA officials stated that there are no plans to begin this phase within calendar year 2014, and they have not established a future time table for implementing this phase.
- **Phase 4—Public record review**: This phase, which has also not been implemented, will be used to locate public records to identify stressors in the veteran's life, such as a bankruptcy or divorce. Officials stated that there are no plans to begin this phase within calendar year 2014, and they have not established a future time table for implementing this phase.

Since beginning the BHAP initiative, VA Central Office has internally issued two interim reports on data and trends from the submitted BHAP templates as part of Phase 1. The reports include information for veterans who died by suicide, both with and without a history of VA health care service utilization. Analyses of data on demographic characteristics, case information, period of service, and risk and protective factors were included for all veterans. Data on clinical characteristics and indicators of increased risk at the time of the veteran's last contact with a VA provider were limited to veterans that utilized VA health care services.

In addition to the BHAP initiative, VA also requires VAMCs to collect and submit data on suicide attempts and completions through the following mechanisms.[24]

- **Suicide Prevention Application Network (SPAN)**: Through SPAN, VAMCs submit information to VA Central Office on the number of veterans that completed suicide, the number of suicide attempts, and indicators of suicide prevention efforts, such as outreach events conducted each month by suicide prevention coordinators.

[24]VAMC officials may send additional information to VISN and VA officials through issue briefs, which document specific factual information regarding unusual incidents, such as deaths, disasters, or anything else that happens at a VAMC, such as a veteran suicide, that might generate media interest or affect care. VAMCs are also required to complete peer reviews for suicides that occur within 30 days of any clinical encounter with a VA clinician. Peer review for quality management is used when there is a need to determine whether a provider's actions associated with an adverse event were clinically appropriate—that is, whether another provider with similar expertise would have taken similar action.

- **Suicide behavior reports**: VAMC clinicians must complete a suicide behavior report when they learn that a veteran attempted or completed suicide and add that report to the respective veteran's medical record. This report includes the date and time of the event, and other observations related to the suicide attempt or completed suicide. According to VA policy, information from suicide behavior reports is used for National Patient Safety reporting requirements and to populate SPAN.
- **Root cause analyses**: Patient safety managers at VAMCs complete root cause analyses for suicide attempts and completed suicides under certain circumstances, such as when the attempt occurs at the VAMC during an inpatient stay or within 72 hours of being discharged from inpatient care. Root cause analyses are used to identify the factors that contributed to adverse events or close calls and any steps VAMCs could implement to prevent similar events in the future.

See appendix III for how VAMC and VISN officials we interviewed told us they have utilized data related to suicides and suicide behavior.

VA Data Show That 10 Percent of Veterans Had MDD and Most Were Prescribed at Least One Antidepressant, but VA Data May Underestimate MDD Prevalence

Data for fiscal years 2009 through 2013 show that about 10 percent of veterans who received health care services through VA were diagnosed with MDD, and of those, 94 percent were prescribed an antidepressant. However, due to diagnostic coding discrepancies we found in a sample of veterans' medical records, VA's data may not accurately reflect the prevalence of MDD among veterans.

VA Data Show About 10 Percent of Veterans Had a Diagnosis of MDD, and Almost All Were Prescribed at Least One Antidepressant

Based on our analysis of VA data from veterans' medical records and administrative sources, 532,222 veterans—about 10 percent of veterans who received health care services through VA[25]—had a diagnosis of MDD from fiscal years 2009 through 2013. Among those veterans, the majority (60 percent) were 35 to 64 years of age. Most (86 percent) were not veterans of the recent conflicts in Iraq and Afghanistan.[26] In addition, most of these veterans were male (87 percent) and the highest proportion was white (68 percent) and non-Hispanic (87 percent). See table 1 for a summary of characteristics of veterans who had a diagnosis of MDD from fiscal years 2009 through 2013.

[25]This estimate is based on published Congressional Research Service data on the number of veterans who received health care services through VA from fiscal years 2009 through 2013 (roughly 5.5 million).

[26]These conflicts include Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn.

Table 1: Characteristics of Veterans Who Received Health Care through the Department of Veterans Affairs and had a Diagnosis of Major Depressive Disorder, Fiscal Years 2009-2013

Veteran characteristics	Number of veterans with major depressive disorder	Percentage of veterans with major depressive disorder
Age		
18-24	3,347	0.6
25-34	54,054	10.2
35-44	57,458	10.8
45-54	96,321	18.1
55-64	164,640	30.9
65-74	115,358	21.7
75+	41,044	7.7
Era of service		
Recent conflicts in Iraq & Afghanistan[a]	75,934	14.3
All other eras	456,288	85.7
Sex		
Male	460,660	86.6
Female	71,562	13.5
Race		
White	361,921	68.0
Black	96,511	18.1
Asian & Pacific Islander	7,098	1.3
Native American	3,484	0.7
Other[b]	23,375	4.4
Not Identified	14,727	2.8
Missing Information	25,106	4.7
Ethnicity		
Non-Hispanic	465,448	87.5
Hispanic	38,577	7.3
Not Identified	14,438	2.7
Missing Information	13,759	2.6

Source: GAO analysis of Department of Veterans Affairs and Department of Defense data. | GAO-15-55

Notes: N=532,222 veterans. Percentages may not equal 100 due to rounding.

[a]These conflicts include Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn.

[b]This category includes veterans who identified themselves as Hispanic or multiple race.

We also found that about 499,000 of the 532,222 (94 percent) veterans who had a diagnosis of MDD from fiscal years 2009 through 2013 were prescribed at least one antidepressant. Of those veterans, the majority (about 73 percent) were dispensed a 12-week supply of an antidepressant at the start of an MDD episode. Fewer veterans (about 58 percent) were dispensed a 6-month supply of an antidepressant over the course of their treatment. Receiving a 12-week supply of an antidepressant can be important for addressing depressive symptoms initially, while continued treatment after remission of depressive symptoms, such as receiving a 6-month supply of an antidepressant, is associated with a decreased risk of relapse, according to the CPG.

VA's Data May Not Fully Reflect the Extent to Which Veterans Have MDD Due to a Lack of Diagnostic Coding Precision by Clinicians

Based on our review of the documentation in 30 veterans' medical records from VA's medical record system, we found that over one-third (11) had diagnostic coding discrepancies. Specifically, these 11 veterans had at least one encounter where the clinician documented a diagnosis of MDD in the veteran's medical record, but the clinician did not code the encounter accordingly. Instead, the clinician coded the encounter as "depression not otherwise specified," a less specific code.[27] According to the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, depression not otherwise specified is to be used to code disorders with depressive features that do not meet criteria for MDD and other depressive disorders,[28] or to indicate depressive symptoms about which there is inadequate or contradictory information.[29] VA's data on the number of veterans with MDD are based on the diagnostic codes associated with patient encounters, so the discrepancies we found indicate that the number of veterans with MDD is most likely not fully reflected in these data. Accurately identifying the veteran population with MDD is critical to assessing Department performance in treating veterans in accordance with the MDD CPG and measuring health outcomes for these veterans. VA Central Office reviewed the 11 medical records where we found coding discrepancies and agreed that the encounters were not

[27]An encounter is a professional contact between a patient and a clinician in an outpatient or inpatient setting; a patient visit can consist of multiple encounters.

[28]Other depressive disorders include dysthymic disorder, adjustment disorder with depressed mood, and adjustment disorder with mixed anxiety and depressed mood.

[29]American Psychiatric Association: *Diagnostic and Statistical Manual*. Depression not otherwise specified is referred to in this edition as depressive disorder not otherwise specified.

coded accurately. According to a VA Central Office official, the encounters we identified were corrected in the veterans' medical record.

According to VHA Handbook 1907.03 - *Health Information Management Clinical Coding Program Procedures*, VAMCs are required to monitor the accuracy of coding and provide training as necessary in order to help ensure accurate coding. VAMC officials from all six sites in our review said that monthly or quarterly coding audits are conducted at their facilities and the findings of those audits are reviewed and action is taken to correct issues with the accuracy and reliability of coding. However, at five of the six VAMCs in our review, those audits focus on billable encounters—that is, encounters that are billed to a third party, such as private health insurance plans—in part because of the potential opportunity for facilities to collect third-party revenue from these encounters.[30] Among the 11 veterans' medical records where we identified coding discrepancies, all of the discrepancies were associated with outpatient, nonbillable encounters, the coding of which, according to a VA Central Office official, is not typically conducted by VAMC medical coders—staff who are trained specifically in medical coding terminology and standards and are responsible for coding inpatient admissions and discharges—or subject to coding audits.

Diagnostic coding in VA's medical record system for outpatient encounters is typically performed by clinicians. VISN officials and VA medical center clinicians we interviewed said that clinicians do not place a lot of importance on selecting a more precise diagnostic code because it does not significantly change the patient care that is provided or the type of treatment prescribed. In addition, in the interest of expediency, clinicians may select a previously used or frequently used diagnostic code for depression rather than take the time to search for a more precise code. For example, within the medical record, clinicians may access a list of previous or current diagnoses applicable to the veteran (commonly referred to as the "problem list") or a list of frequently used diagnostic codes in the facility. According to VISN and VAMC officials, the problem list is not typically kept up to date by clinicians and as a result, MDD may not be listed and readily available for clinicians to select. As a result of our

[30]Officials at one VAMC in our review said that their facility conducts annual audits of nonbillable encounters, in part, to track the productivity of their providers and to maximize the amount of funding allocated to their facility by VA Central Office based on workload measures.

review, VA Central Office officials reported that they had discovered a software mapping error in VA's medical record system where the selection of MDD as a diagnosis when using a keyword search function may result in the selection of the depression not otherwise specified diagnostic code by mistake.[31] Officials stated that they anticipate that the software error—which applies to all VAMCs—would be fixed by November 2014. Officials also stated that the solution would apply only to those encounters coded from that point going forward and would not retroactively correct any coding discrepancies that may have occurred before the error was addressed. VA Central Office officials could not tell us if any of the 11 coding discrepancies that we identified were a result of this software error.

Officials at most of the six VISNs we spoke with do not conduct reviews of medical coding done by clinicians. However, as a result of our inquiry, one VISN we interviewed reported in the late spring of 2014 that it had extracted data on MDD-related encounters and noticed the high use of depression not otherwise specified coding for the facilities within its VISN, as well as all VAMCs nationwide. Officials from this VISN said the lack of coding specificity has implications for being able to accurately examine health outcomes related to the treatment of depression and that they are planning to further analyze encounter data within their VISN to determine the appropriateness of diagnostic coding based upon medical record documentation. As of September 2014, the VISN had not reported any additional steps to address this issue.

[31]For example, according to a VA Central Office official, if the clinician used the keyword search function and searched under the word "major depression", "major depressive disorder" would be returned as a possible diagnosis choice for selection. Currently, as a result of the software mapping error, if this selection is made, the encounter would be coded as depression not otherwise specified.

Not All Veterans in Our Review Received CPG-Recommended Care and VA Lacks Mechanisms to Determine Whether This Care Is Provided

Based on the three CPG recommendations we selected, veterans in our review with MDD who have been prescribed antidepressants did not always receive care as recommended in the MDD CPG. Additionally, VA does not know the extent to which veterans with MDD who have been prescribed antidepressants are receiving care as recommended in the CPG, and VA Central Office has not developed mechanisms to determine the extent to which mental health care delivery conforms to the recommendations in the MDD CPG.

Veterans We Reviewed Did Not Always Receive Care As Recommended

We found that almost all of the 30 veterans with MDD who have been prescribed antidepressants included in our review did not receive care in accordance with the three MDD CPG recommendations we reviewed. VA policy states that antidepressant treatment must be consistent with VA's current, evidence-based CPG.[32] However, VA Central Office mental health officials were unable to tell us what it means to provide care that is consistent with the CPG, because, while a veteran's treatment should be informed by the CPG recommendations, determining the extent to which the treatment is consistent with CPG recommendations would need to be done on a veteran-by-veteran basis. The CPG is intended to reduce practice variation and help improve patient outcomes, but without an understanding of the extent to which veterans are receiving care that is consistent with the CPG, VA may be unable to ensure that it meets the intent of the CPG and improves veteran health outcomes.

Through our review of 30 medical records from the six VAMCs we selected, we found examples of deviations from the CPG recommendations for almost all veterans in our review.[33] Table 2 below depicts the specific recommendations we reviewed and the number of veterans that did not receive care consistent with the corresponding CPG recommendation.

[32] *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook.

[33] We reviewed five medical records from each of the six VAMCs we selected to determine whether veterans at these VAMCs were receiving care consistent with select recommendations from the CPG.

Table 2: Number of Veterans in GAO's Sample Not Receiving Care As Recommended in the Clinical Practice Guideline (CPG) for Major Depressive Disorder (MDD)

CPG recommendation	Number of veterans not receiving care as recommended in the CPG for MDD
To enhance antidepressant treatment, veterans should be educated on when to take the medication, possible side effects, risks, and the expected duration of treatment, among other things	6 of 30 veterans lacked documentation of patient education when the medication was prescribed
Standardized assessments of depressive symptoms, such as the Patient Health Questionnaire-9, should be used to monitor treatment at 4-6 weeks after initiation of treatment and after each change in treatment	26 of 30 veterans were not assessed using a standardized assessment tool at 4-6 weeks after initiation of treatment 18 of 30 veterans were not assessed using a standardized assessment tool at any encounter[a] 10 of 30 veterans did not have a follow-up encounter that occurred 4-6 weeks after initiation of treatment[b]
A plan should be developed that addresses the duration of antidepressant treatment, among other things	1 veteran of 30 did not have a planned date for follow up and plan for future care documented in the veteran's medical record at the initial encounter

Source: GAO analysis of Department of Veterans Affairs (VA) data. | GAO-15-55

Note: We included 30 veterans in our review. Our review began with the encounter during which a VA clinician ordered an antidepressant to treat depressive symptoms (initial encounter) and five follow-up encounters with a VA clinician, or sooner if the veteran did not have five follow-up encounters. Our review was limited to encounters during which the antidepressant treatment was reviewed, including encounters during which side effects and treatment effect were assessed, but no change was made to medication orders.

[a]Of the 30 veterans included in our review, only 6 were assessed using a standardized assessment at the initial encounter where antidepressant medication was prescribed. VA Central Office officials explained that they would expect a standardized assessment to be conducted at the start of an antidepressant to establish a baseline score.

[b]Three veterans did not receive a follow-up appointment at all. Two veterans did not show for scheduled appointments that were within the CPG recommended time frame. Five veterans did not have a follow-up encounter until after 6 weeks.

For example, the CPG recommends that veterans' depressive symptoms be assessed at 4-6 weeks after initiation of antidepressant treatment to determine the efficacy of the treatment. However, medical records of 10 of the 30 veterans we reviewed indicated that they did not have a follow-up encounter within the CPG's recommended 4-6 week time frame. Of those 10 veterans,

- 3 veterans did not have any follow-up encounters related to mental health;
- 2 veterans did not show for scheduled appointments that were within the CPG recommended time frame; and

- 5 veterans did not have a follow-up encounter until after 6 weeks. This follow up ranged from 7 weeks to 50 weeks after the initial encounter.[34]

Some clinicians at VAMCs we visited described instances in which they generally do not follow the CPG recommendations.[35] For example, not all clinicians use a standardized assessment to evaluate a veteran's symptoms. Officials from two VAMCs we visited explained that they do not routinely use the PHQ-9. According to one of these VAMCs, the standard of care is a clinical interview and observation. However, the CPG recommendation states that the PHQ-9 combined with a clinical interview should be used to obtain the necessary information about symptoms and symptom severity. It also states that the PHQ-9 improves diagnostic accuracy and aids treatment decisions by quantifying symptom severity. Furthermore, clinicians may also prefer different time frames for follow up, which are not always consistent with the CPG recommendation. For example, one clinician told us that he tries to see the veteran 3 weeks after the initial appointment, and clinicians at another VAMC like to see the veteran within 6 weeks, but told us that this is sometimes difficult due to scheduling constraints.[36]

[34]Of these 5 veterans, 2 had treatment plans in the medical record that did not specify a time frame for follow up. One veteran returned in 7 weeks, as prescribed in the veteran's treatment plan. However, the remaining 2 veterans had a time frame in their treatment plan, but no explanation for why the follow-up encounter occurred outside this time frame. The first veteran's treatment plan instructed the veteran to return in 6 weeks; however, the veteran's follow-up encounter occurred approximately 12 weeks after the initial encounter. The second veteran's treatment plan instructed the veteran to return in 6-8 weeks, but the veteran was not seen until approximately 50 weeks after the initial encounter.

[35]As a result of our review, officials at one VAMC told us that they are developing plans to work with clinicians at the VAMC to implement measurement tools, including the PHQ-9.

[36]VA's Office of Inspector General (OIG) documented concerns about the timeliness of veterans' access to follow-up mental health care, which could affect the ability of veterans to receive follow-up with a clinician after beginning or changing antidepressant treatment. VA OIG, *Veterans Health Administration: Review of Veterans' Access to Mental Health Care* (Washington, D.C.: Apr. 23, 2012).

VA Lacks Mechanisms to Determine the Extent to Which Veterans Are Receiving Care Consistent with CPG Recommendations

VA does not know the extent to which veterans are receiving care consistent with the MDD CPG. While deviations from recommended practice may be appropriate in many cases due to clinician discretion, VA has not fully assessed whether these examples are acceptable deviations from the CPG. According to the federal internal control standard for risk assessment, agencies should comprehensively identify risks, assess the possible effects, if any, and determine what actions should be taken to mitigate any significant risks. VA Central Office has not developed a mechanism to fully identify deviations that could impede veterans' recovery that may result when VAMCs do not provide care consistent with the MDD CPG. VA Central Office officials explained that the CPG recommendations are guidelines that clinicians can use to inform and guide clinical decision making. VA officials told us that VA cannot require the use of all recommendations in all cases; rather, CPG recommendations should be applied on a case-by-case basis based on the needs of the veteran and with clinician judgment. One official also said it would be difficult to check every CPG recommendation to ensure that clinicians are providing care consistent with the CPG, but stated that VA could identify for review those recommendations that may put veterans' health at risk if not followed.[37] However, with no mechanism to assess whether the care provided is consistent with the CPG, VA is unable to ensure that deviations from recommended care are identified.

While monitoring full compliance with CPG recommendations may be difficult, there are nevertheless ways to address the issue. In fact, VA Central Office and some VAMCs have implemented mechanisms to determine the extent to which veterans are receiving care that is consistent with some of the CPG recommendations; however, these mechanisms do not fully assess all deviations that could impede a veteran's recovery, as illustrated by the following.

[37]In a June 2014 report, the Institute of Medicine also raised concerns with VA clinicians' adherence to CPG recommendations. This report reviewed the *VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress* and stated that VA does not have a mechanism for the systematic collection and analysis of data for assessing the quality of care for post-traumatic stress disorder and that, as a result, VA often does not know whether veterans have received evidence-based treatments or whether these treatments are producing positive outcomes. The Institute of Medicine recommended that VA use evidence-based treatments as the treatment of choice for post-traumatic stress disorder, and these treatments should be delivered with fidelity to their established protocols. Institute of Medicine, *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations Report Brief* (Washington, D.C.: June 2014).

- In fiscal year 2014, VA began to review mental health care delivery at VAMCs through a psychopharmacology quality improvement initiative consisting of a series of prescribing practices metrics, although this initiative does not fully assess the extent to which care is consistent with the MDD CPG.[38] One metric—the proportion of veterans with depression prescribed three or more concurrent antidepressant medications for 60 or more continuous days—relates to 2 of the over 200 MDD CPG recommendations.[39] According to one VA Central Office official, the initial phase of the initiative is focused on decreasing variability in prescribing practices among VAMCs. To start the initiative, VA compiled metric profiles for each VAMC, which included a description of how each VAMC performed for all metrics as well as the performance of each VAMC relative to the VISN and national averages. VA requires that all VAMCs address metrics where performance was lower than the national average. Currently, VA is assisting VAMCs with developing action plans to address these metrics. Because the initiative is in the early stages, it is too soon to determine how VA Central Office and VAMCs will review and remedy deviations from the two CPG recommendations addressed by this

[38]VA's OMHO developed the psychopharmacology initiative in fiscal year 2014. This initiative is intended to address four areas: (1) possible overprescribing, (2) possible problems in clinical management, (3) misalignment between prescribing and diagnosis, and (4) missed opportunities. The metrics generally assess all veterans with any depression diagnoses, such as depression not otherwise specified; only one metric is specific to MDD. VA Central Office officials explained that data for this initiative are pulled from clinical and administrative records, but that extracting data can be challenging because, for example, clinicians may not be recording data in an extractable field in the medical record. VA Central Office officials also told us that they collect data on the number of veterans who receive 12-week and 6-month supplies of antidepressant medication, which relates to a CPG recommendation stating that, for veterans who achieve remission with antidepressants, treatment should be continued at the same dose for an additional 6-12 months to decrease the risk of relapse. *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder* (May, 2009) pg. 73.

[39]Specifically, these CPG recommendations state that veterans who are diagnosed with MDD should receive an initial trial of a single antidepressant, and that a second antidepressant medication may be considered for veterans who have had a partial response to treatment with one antidepressant. *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder* (May, 2009). Other antidepressant metrics include: the proportion of veterans with depression receiving medication from three or more of four psychotropic classes (including antidepressants) for 60 or more continuous days; the proportion of inpatient or outpatient initial visits for new MDD diagnosis with antidepressant receipt where there is no coverage for 84 days out of the first 114 days following the initial antidepressant fill; and the proportion of antidepressant prescriptions given with no medical or psychiatric indication. However, these metrics do not relate to specific recommendations in the CPG.

initiative. According to VA Central Office officials, the psychopharmacology quality improvement initiative is a mechanism VA currently has to look at CPG recommendations, and VA could add additional metrics addressing other CPG recommendations in the future. However, VA Central Office officials stated that other CPG recommendations would require a more in depth analysis, such as medical record reviews, and it would be difficult to develop metrics for some of the recommendations.[40]

- While VA Central Office does not have a mechanism to determine the extent to which VAMCs are providing care consistent with a majority of the CPG recommendations, some VAMCs have implemented a software system to help ensure that veterans with MDD who are prescribed antidepressants receive care consistent with the CPG when the veteran is treated in a primary care clinic.[41] At the time of our site visits, three of the VAMCs we visited were using such a system—the Behavioral Health Laboratory (BHL).[42] The BHL is

[40]VA also provides VAMCs data on the number of veterans screened annually using a standardized screening tool, a two item Patient Health Questionnaire (PHQ-2) and the percentage of veterans who screen positive for depression and have a timely suicide behavior evaluation completed. These measures meet CPG recommendations for annual screening for MDD and evaluation of suicide risk with a positive depression screen. Another mechanism VA uses to assess mental health care at VAMCs is site visits conducted by VA's OMHO. During these site visits, OMHO assesses, for example, how the number of veterans screened annually for depression compares to the national average as well as any trends within the VAMC. According to OMHO, the purpose of these site visits is to assess mental health care at individual VAMCs, specifically implementation and adherence to VA standards for mental health services. Once OMHO has identified both exemplary areas and areas for growth, OMHO then works with the mental health lead at the corresponding VISN to develop a strategic action plan for the VAMC, which will be monitored for implementation progress on a quarterly basis. However, these site visits do not look at specific CPG recommendations.

[41]Officials at one VAMC we visited told us that they use a clinical tool to track veterans being treated for mental health conditions. The mental health tool includes 67,349 unique patients, and an official explained that they can run queries of the clinical tool—for example, for veterans participating in substance abuse treatment who did not return for a drug screen—by pulling both process and outcome variables including diagnostic codes, lab results, and medication lists.

[42]VA policy states that VAMCs must have integrated mental health services that include co-located collaborative care and care management. Care management can be based on the BHL, Translating Initiatives for Depression into Effective Solutions (TIDES), or other evidence-based strategies approved by the Office of Mental Health Services. According to VA, TIDES facilitates collaboration between primary care clinicians and mental health specialists with support from a depression care manager, who, under the supervision of a mental health specialist, assists the primary care clinician in the assessment and ongoing management of depressed patients.

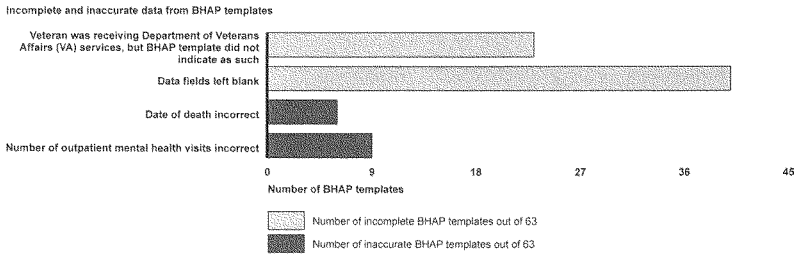
designed to manage the behavioral health needs of veterans through telephone or in-person visits. As part of the system, clinicians can use a structured interview—including a PHQ-9—that assesses veterans' mental health symptoms in a way that is consistent with the CPG recommendation for follow-up assessment. Although the BHL can be used to help ensure care is provided consistent with a few of the recommendations in the CPG, the BHL is not used to monitor all veterans prescribed antidepressants. Generally, VAMCs use the BHL to monitor veterans being treated for mental health conditions, such as MDD, in primary care clinics, and to participate, veterans can be referred by their primary care clinician or request to participate.[43]

Demographic and Clinical Data VA Collects on Veteran Suicides Were Not Always Complete or Accurate, and VAMCs Applied Instructions for Gathering Suicide Data Differently

We found that demographic, clinical, and other data submitted to VA Central Office on veteran suicides were not always completely or correctly entered into the BHAP Post-Mortem Chart Analysis Templates—a mechanism by which VA Central Office collects veteran suicide data from VAMCs' review of veterans' medical records. (Figure 1 shows the number of BHAP templates we found with incomplete or inaccurate data.) Moreover, VAMCs interpreted and applied instructions for completing the BHAP templates differently. We also found that most VAMCs and VISNs we reviewed and VA Central Office did not review suicide data for accuracy.

[43]According to officials at one VAMC we visited, clinicians previously used pharmacy data on a weekly basis to determine whether there were any veterans with new antidepressant orders from primary care who were not referred to the BHL. Officials told us that they stopped running the weekly query, since they consistently found that all eligible veterans had been referred to the BHL. However, in advance of our site visit, officials ran the query again and noted that some veterans were not being referred to the BHL. As a result, they plan to resume completing the weekly queries.

Figure 1: Number of Behavioral Health Autopsy Program (BHAP) Post-Mortem Chart Analysis Templates with Incomplete or Inaccurate Data



Source: GAO analysis of VA data. | GAO-15-55

Veteran Suicide Data Are Incomplete

We found that over half of the 63 BHAP templates we examined had incomplete information.[44] The data either lacked veteran enrollment information, or other specific fields were omitted. Moreover, the data were lacking entirely for certain known veteran suicides. Incomplete data limits VA Central Office's ability to identify information that can be used to help VA Central Office develop policy and procedures to prevent veteran deaths.

Lack of veteran enrollment information. Approximately one-third (23) of the BHAP templates we reviewed did not indicate whether the veteran was enrolled in VA health care services, even though the veteran had a VA medical record.[45]

[44]We analyzed BHAP templates from five of the VAMCs at the time of our site visit or at the time we requested the BHAP templates. One VAMC had not completed any BHAP templates at the time of our site visit because they did not have a veteran die by suicide since the beginning of the BHAP initiative. Therefore, our analysis does not include BHAP templates from this VAMC.

[45]This field in the BHAP template states: "Is this case concerning a Veteran who was enrolled in VA Health Care Services?" For those veterans who were being seen in the VA, the box associated with this field should be checked.

- Eight did not indicate that the veteran had received VA services when the templates were submitted by three of the VAMCs in our review, even though these VAMCs provided care to these veterans.
- Fifteen BHAP templates submitted by two VAMCs in our review originally indicated that the veteran was receiving VA care; however, when we reviewed the submitted BHAP templates we received from VA Central Office for the same 15 veterans, the BHAP templates did not indicate that the veteran was being seen in the VA.[46]

VA Central Office used enrollment information when compiling the most recent BHAP interim report, which is part of VA Central Office's quality improvement efforts for its suicide prevention program.[47] Specifically, VA Central Office included clinical data in the BHAP interim report only for veterans utilizing VA services. Therefore, clinical data for the 23 veterans we identified would not be included in the interim report. Missing one-third of the data from its analysis, as was the case in our sample, could have a detrimental effect on the trends VA Central Office reports and uses to improve its suicide prevention efforts.

Requested data was omitted. Forty of the 63 BHAP templates we reviewed included various data fields where no response was provided, resulting in incomplete data. For example, for 19 templates, VAMC staff did not enter requested data as to whether the veteran had all or some of 15 active psychiatric symptoms within 12 months prior to the veteran's date of death.[48] Also, 9 templates did not include an answer for the number of previous suicide attempts by the veteran. Officials from one VAMC told us that they left this field blank if the veteran did not have any previous suicide attempts, rather than entering a "0," even though the

[46]VA Central Office officials stated that this field could have become unchecked prior to submission of the template to Central Office, but that it was not the result of a programming error. For example, the box may have become unchecked after the VAMC official saved the template to a local location, but prior to the VAMC submitting the template to VA Central Office.

[47]According to one VA Central Office official, for the first interim report, officials matched veterans from the BHAP templates to medical record information to determine whether the veteran was receiving VA health care services.

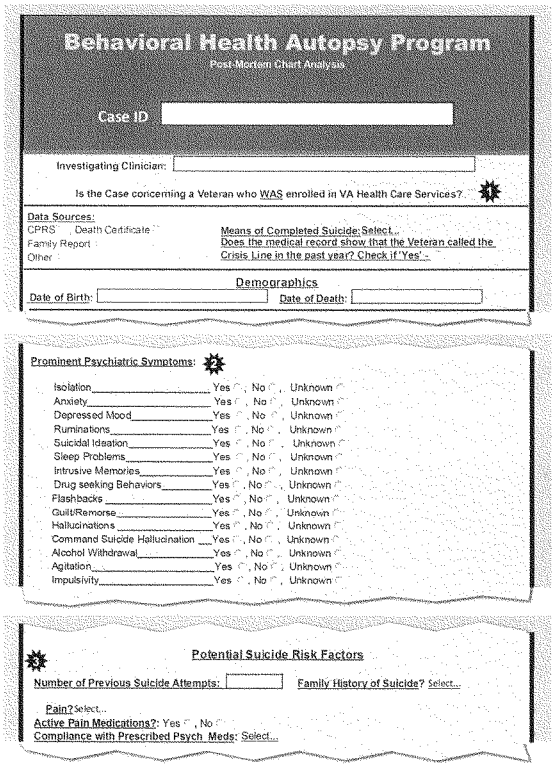
[48]The 15 psychiatric symptoms in the BHAP template are isolation, anxiety, depressed mood, ruminations, suicidal ideation, sleep problems, intrusive memories, drug seeking behaviors, flashbacks, guilt/remorse, hallucinations, command suicide hallucination, alcohol withdrawal, agitation, and impulsivity.

BHAP Guide states that officials should enter the appropriate number of previous suicide attempts. Officials at one VAMC told us that fields are sometimes left blank if the standardized answers available on the BHAP template are not adequate; that is, the answer for that veteran does not fit into one of the answers provided on the BHAP template.[49] Officials at two VAMCs stated that it is sometimes easy to overlook fields in the BHAP template, resulting in unanswered questions.

Filling in all fields in the BHAP template, rather than leaving the field blank, is important because some blank fields are counted as "missing" or "no" in the analysis conducted by VA Central Office for the BHAP interim reports. This, in turn, could affect the suicide trends reported. For example, for the number of previous suicide attempts, blank fields are counted as "missing" in the BHAP interim report, rather than "0" previous suicide attempts as officials from one VAMC intended. In other cases, such as for psychiatric symptoms, missing fields are counted as "no," meaning that the veteran did not have these symptoms. In at least one BHAP template, the answer for the psychiatric symptom of isolation was left blank, and would therefore be counted as negative in the interim report despite the fact that officials from the one VAMC told us that the veteran did have this symptom. See figure 2, which provides an excerpt of the fields from the BHAP template in which VAMCs provided incomplete data.

[49]For example, the template answers for psychiatric symptoms originally included "yes" and "no." The template has been updated to also include "unknown," but this answer was not an option for all templates in our review. However, officials at two VAMCs provided us with the answers for fields that were left blank, including the fields for psychiatric symptoms.

Figure 2: Excerpts of the Department of Veterans Affairs' (VA) Behavioral Health Autopsy Program (BHAP) Template in Which Selected VA Medical Centers Submitted Incomplete Data



This box should be checked to indicate whether the veteran was enrolled in VA health care services.

The corresponding bubble should be filled in to indicate active symptoms the veteran may have experienced anytime within 12 months prior to the date of death.[a]

This box should contain the number of previous suicide attempts, as indicated in the veteran's electronic medical record.

Source: GAO analysis of VA documents. | GAO-15-55

[a]The BHAP template has changed over time and "unknown" has not always been an option in this section of the BHAP template.

Data were lacking entirely for certain known veteran suicides. We found that VAMCs did not always submit BHAP templates for all veteran suicides known to the facility, as required by the BHAP Guide. VA Central Office does not have a process in place to determine whether it is receiving the BHAP templates for all known veteran suicides.[50] For example, one VAMC had completed 13 BHAP templates at the time of our site visit but had not submitted them; however, neither the VAMC nor VA Central Office were aware that these templates had not been submitted until after we requested them from VA Central Office. The suicide prevention coordinator at this VAMC told us that the BHAP templates were forwarded to another official at the VAMC, rather than being submitted through VA Central Office's process, and that the BHAP templates were never submitted. As a result of our inquiry, the VAMC submitted these templates to VA Central Office. In another example, officials at a different VAMC told us that, at the time of our site visit, they had recently begun completing and submitting BHAP templates, beginning with veteran suicides occurring in fiscal year 2014. VA Central Office officials told us that VAMCs can start submitting BHAP templates at any point, and officials are not requiring the VAMCs to go back and submit information on all suicides since October 1, 2012. However, this practice is contrary to VA policy, which states that VAMCs should submit BHAP templates for all suicides known to the facility and reported on or after October 1, 2012.

Veteran Suicide Data Are Inaccurate

Of the 63 BHAP templates we reviewed, we found numerous instances of inaccurate data submitted on BHAP templates, as illustrated by the following examples.

- **Incorrect date of death**: Six BHAP templates included a date of death that was incorrect based on information in the veteran's medical

[50]One VA Central Office official told us that for the first BHAP interim report, officials matched the number of suicide behavior reports to the number of BHAP templates using the veterans' social security numbers to determine that a BHAP template was submitted for each completed suicide behavior report. According to VA Central Office officials, this process was not conducted for the most recent BHAP interim report.

record.[51] The difference in the dates of death in the veterans' medical records and the dates of death in the BHAP templates ranged from 1 day to 1 year. For example, one BHAP template indicated that the veteran died in the year after the veteran's actual date of death. Another BHAP template appeared to use the date the suicide behavior report was completed, rather than the veteran's actual date of death. The suicide behavior report was completed 69 days after the veteran's date of death.[52] The accuracy of the date of death recorded in the BHAP template is important because it is used as a point of reference to calculate other fields, such as the number of mental health visits in the last 30 days.

- **Incorrect number of mental health visits**: Nine BHAP templates included the incorrect number of outpatient VA mental health visits in the last 30 days.[53] For example, one BHAP template indicated that the veteran had five outpatient mental health visits, including three non-mental health visits that should not have been included in the total number of mental health visits for this veteran. Another BHAP template indicated the veteran had been seen once by a mental health provider in the last 30 days; however, we found in reviewing the medical records that this veteran had not been seen by a mental health provider during this time period. This veteran would be included in the BHAP interim report as having a mental health visit, and, as a result, VA's data would include an inaccurate count of the number of veterans with mental health visits in the last 30 days.[54] Without accurate information, VA cannot use this information to determine whether policies or procedures need to be changed to ensure that

[51]We could not confirm date of death for two BHAP templates because the veterans' medical records did not contain a date of death. When confirming the lack of date of death in the medical records with the VAMC, officials stated that they took the date of death for one of the templates from the suicide behavior report. However, we did not find a suicide behavior report in the veteran's medical record.

[52]Two BHAP templates had dates of death that were 1 day off, one BHAP template was off by 3 days, and one BHAP template had a date of death off by 5 days.

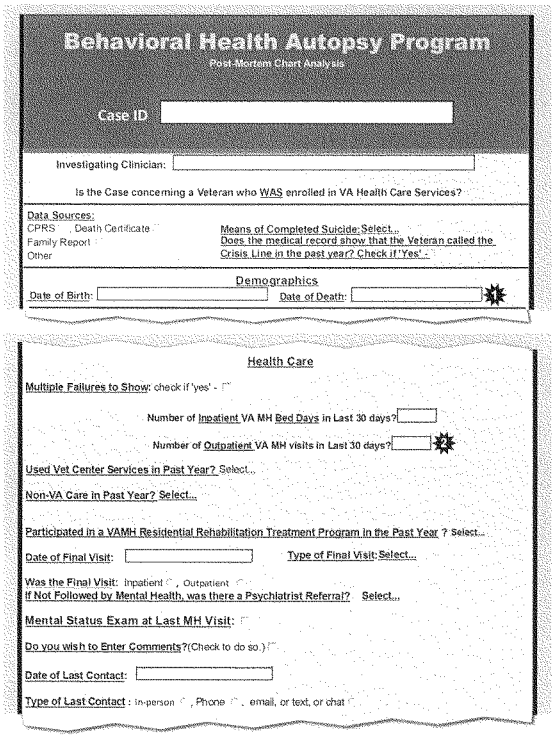
[53]Although the BHAP template asks for the number of mental health visits, VA Central Office officials told us that they expect VAMCs to report mental health encounters, rather than visits. An encounter is a professional contact between a patient and a clinician in an outpatient or inpatient setting; a patient visit can consist of multiple encounters.

[54]According to VA Central Office officials, missing information in this field is treated as "0" in the interim report.

veterans at high risk for suicide are being seen more frequently by a mental health provider to help prevent suicides in the future.

See figure 3, which provides an excerpt of the fields from the BHAP template in which VAMCs provided inaccurate data.

Figure 3: Excerpts of the Department of Veterans Affairs' (VA) Behavioral Health Autopsy Program (BHAP) Template in Which Selected VA Medical Centers Submitted Inaccurate Data



1 This field should include the month, date, and year of the veteran's death.

2 This field indicates the total number of outpatient mental health visits in the last 30 days.

Source: GAO analysis of VA documents. | GAO-15-55

VAMCs Have Interpreted and Applied Instructions for Completing the BHAP Templates Differently

We found several situations where VAMCs interpreted and applied instructions for completing the BHAP templates differently, as illustrated in the following examples.[55]

- We found inconsistencies in how different VAMCs arrived at answers provided in the BHAP templates. For example, one VAMC included a visit to an immunization clinic as the veteran's final visit, while another VAMC did not include this type of visit, even though this was the last time the veteran was seen in person. The BHAP Guide indicates that the final visit should be the last time the veteran had in-person contact with any VAMC staff, but the BHAP Guide does not identify the different types of visits that should be counted.[56] VA Central Office officials stated that a visit to an immunization clinic should be included as the final visit with the veteran. When VAMCs do not provide consistent data, VA Central Office will receive and use inconsistent data in preparing its trend reports, such as BHAP interim reports, which are intended to be used to improve suicide prevention efforts.
- We also found instances in which BHAP templates included information that did not conform to the instructions in the BHAP Guide on how to complete the BHAP medical record reviews.
  - **Last contact did not always represent the last time a VAMC official spoke with the veteran**: The BHAP Guide instructions specify that the last contact recorded in the BHAP template should be the last recorded interaction with the veteran, which could be in person, through a phone call, or through email. Five of the 63 BHAP templates we reviewed did not indicate the last time an official spoke directly to the veteran. One BHAP template counted a phone call with a veteran's spouse after the veteran's death as the last contact with the veteran. The BHAP template also counted this phone conversation as an "in-person" interaction. The remaining four BHAP templates included a date for the last contact that was prior to the date for the veteran's final in-person visit at the VAMC. In these instances, the veterans' in-person visit

[55]The BHAP Guide can be used as a reference when completing the BHAP template because the BHAP Guide contains specific time frames for some of the fields, several of which are not outlined in the BHAP template.

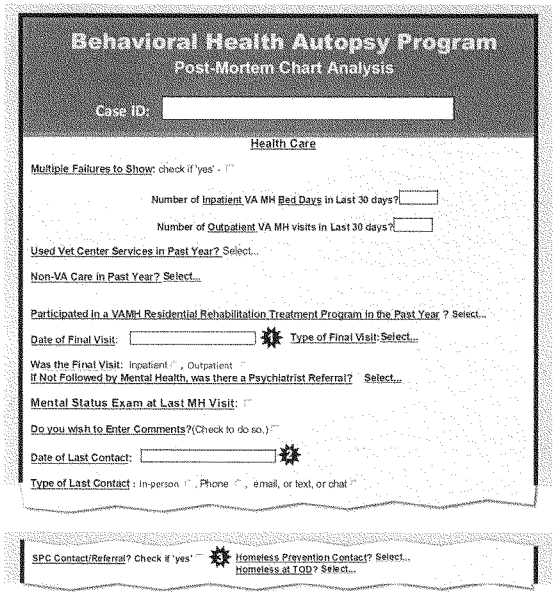
[56]The BHAP Guide states that the final visit could include a mental health or a dental visit, but does not specify if a visit to an immunization clinic should be counted. The BHAP template includes a field for type of visit. One option as an answer for this field is "other," and the type of visit can be included in a text box in the template.

should have been counted as the last contact. From this flawed information, VA would not be able to determine reliable trends for the amount of time between the last contact with the veteran and the veteran's date of death for reports that it prepares, such as the BHAP interim report.

- **Suicide prevention coordinator contact and referral not within BHAP time period**: The BHAP Guide specifies that VAMCs should indicate in the BHAP template whether there was a suicide prevention coordinator contact or referral made within 3 months prior to the veteran's date of death. In 3 of the 63 cases we reviewed, we found that the suicide prevention coordinators checked the box indicating that they saw the veteran or had a referral within 3 months of the veteran's death. However, in each of these cases we found that the contact was made more than 3 months prior to the veteran's death, so it should not have been counted. A suicide prevention coordinator from one VAMC said she was unaware of the time period requirement and a suicide prevention coordinator at another VAMC stated that time frames should be added to the BHAP template, rather than just included in the BHAP Guide. The BHAP interim reports include the number of veterans that had a suicide prevention coordinator contact or referral, and by including information on contacts or referrals that are outside the BHAP Guide time frame, these reports may be at risk of misreporting trends in this area.

See figure 4, which provides an excerpt of the fields from the BHAP template in which VAMCs provided inconsistent data.

Figure 4: Excerpts of the Department of Veterans Affairs' (VA) Behavioral Health Autopsy Program (BHAP) Template in Which Selected VA Medical Centers Submitted Inconsistent Data



1 The final visit should include the last time the veteran had in-person contact with VA staff.

2 The date of last contact should be the last recorded personal interaction with the veteran, including in-person visits, phone calls, or contact via email.

3 The BHAP Guide indicates that this field should include referrals within 3 months of the date of death; however, this time frame is not specified in the BHAP template.

Source: GAO analysis of VA documents. | GAO-15-55

VA policy and guidance states that the BHAP template should be completed for all suicides known to the facility, but at the five VAMCs we visited, these data were not always being reported.[57] However, the policy

[57]VA Central Office has provided policy on the BHAP template through a memorandum and has also provided suicide prevention coordinators with a BHAP Guide, which explains how to fill out the BHAP template.

and instructions do not explicitly state that veterans not being seen by VA should be included, and in the absence of this declaration, some VAMCs interpreted the instructions to mean that only veterans being seen by VA should be included in the data submitted. Therefore, two VAMCs have submitted data only for veterans being treated by VA, while the others include data on all known veteran suicides—whether they have been treated by VA or not. This further adds to the inconsistencies in the information that VAMCs submit on the BHAP templates. VA Central Office officials told us that BHAP templates should be completed for both veterans utilizing VA health care services, as well as those veterans not being seen in the VA, and that this requirement has been discussed at training sessions and during conference calls with suicide prevention coordinators. For example, during a suicide prevention conference in November 2013, a VA Central Office official informed participants that the BHAP template should be completed for all suicides reported through SPAN, which VA Central Office officials previously told us includes veterans that were not receiving VA care. The inconsistency in VAMC officials' understanding of which veterans should have a completed BHAP template results in inconsistent data being reported to VA Central Office. While VA was in the process of updating its suicide prevention coordinator manual, we brought this issue to VA's attention. In August 2014, VA made modifications to the manual that indicated that VA is changing its policy—now requiring that the BHAP template should be completed only for veterans receiving VA services. However, the guidance continues to be unclear on whether suicide prevention coordinators should complete BHAP templates for veterans not receiving VA care.[58]

VAMCs, VISNs, and VA Central Office Do Not Review Suicide Data

We found that BHAP templates are not being reviewed by VA officials at any level for accuracy, completeness, and consistency. Therefore, our findings at five VAMCs could be symptomatic nationwide and other VAMCs may also be submitting incomplete, inaccurate, and inconsistent suicide-related information and VA may not be getting the data it needs across the Department to make appropriate resource decisions and develop new policy. VA policy states that it is the VISN's and VAMC's decision whether to conduct reviews of BHAP data prior to submission to

[58]In its comments on a draft of this report, VA stated that in September 2014 it provided guidance to VAMCs to complete BHAP templates for veterans not receiving VA services.

VA Central Office. With few exceptions, VAMCs and VISNs we visited generally do not conduct data checks on the information submitted in the BHAP templates. Additionally, VA Central Office does not review the information for accuracy and completeness in the BHAP templates it receives. This approach is inconsistent with internal control standards for the federal government, which state that agencies should have controls over information processes, including procedures and standards to ensure the completeness and accuracy of processed data.[59]

Officials at one VAMC told us that VAMC staff compare the BHAP data and the veteran's medical record prior to submitting the BHAP template to VA Central Office to ensure accuracy. In response to our review, another VAMC implemented a procedure to check the accuracy and completeness of their BHAP templates prior to submission. The procedure at this VAMC requires the suicide prevention coordinator and case manager to independently complete the BHAP template and compare their responses. The BHAP templates are then reviewed by the Assistant Mental Health Clinic Director prior to submission.

We also found that VA lacks sufficient controls to ensure the quality of the existing BHAP data. For example, VA Central Office officials said there are no automated data checks to ensure the accuracy of data it uses for the BHAP interim report, such as checking to ensure that the date of last contact with the veteran that is recorded in the BHAP template is not after the veteran's date of death. Although officials removed apparent duplicates in submitted BHAP templates by matching the veteran's name and social security number while compiling the data for the most recent BHAP interim report, they do not conduct data checks to help identify some of the incomplete or inaccurate data we found in our review.

Conclusions

Given the negative effects of MDD, it is important to provide timely, evidence-based treatment for veterans with MDD, and VA's ability to monitor these veterans is critical to ensuring positive outcomes. However, our findings demonstrate that VA may not be fully aware of the population of veterans with MDD due to a lack of coding precision by clinicians. This can limit VA's ability to assess the Department's performance in treating

[59]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

veterans as recommended in the MDD CPG and in measuring health outcomes for veterans. Additionally, VA does not have mechanisms in place to ensure that the Department is able to identify deviations from CPG-recommended care and remedy those that could impede veterans' recovery. Even if VA did have mechanisms in place, the coding discrepancies we identified would limit VA's ability to extract accurate data on all veterans diagnosed with MDD, therefore hindering VA's ability to determine the extent to which veterans are receiving care consistent with the CPG recommendations for MDD. The CPG recommendations are meant to improve veteran outcomes by providing maximum relief from the debilitating symptoms of MDD, and VA cannot ensure that the care veterans receive is consistent with those recommendations.

The existence of incomplete, inaccurate, and inconsistent information submitted through VA's BHAP templates limits the Department's ability to accurately evaluate its suicide prevention efforts and identify trends in veteran suicides through the BHAP initiative. Specifically, data drawn from incomplete, inaccurate, and inconsistent BHAP templates limit the Department's opportunities to learn from past veteran suicides and ultimately diminish efforts to improve its suicide prevention activities. VAMCs, VISNs, and VA Central Office generally lack a process to ensure that the data that are submitted and used by VA Central Office to identify trends in veteran suicides are complete, accurate, and consistent. Checking and verifying the data submitted to VA Central Office would help ensure that changes made to suicide prevention efforts by VAMCs, VISNs, and VA are based on actual trends in veteran suicides. Without clear VA Central Office instructions to guide how VAMCs and VISNs should complete BHAP templates and report suicide data, the validity of suicide data and the effectiveness of VA's actions will be hampered.

Recommendations for Executive Action

We recommend that the Secretary of Veterans Affairs direct the Under Secretary for Health to take the following six actions:

To more accurately estimate the prevalence of MDD and identify enrolled veterans with MDD, VA should

- identify the extent to which there is imprecise diagnostic coding of MDD by further examining encounters with a diagnostic code of depression not otherwise specified, which could be incorporated into VAMCs' ongoing review of diagnostic coding accuracy, and

- determine and address the factor(s) contributing to the imprecise coding based on the results of those examinations. For example, feedback and additional training could be provided to clinicians regarding the importance of diagnostic code accuracy, or VA's medical record could be enhanced to facilitate the selection of a more accurate diagnostic code.

To ensure that veterans are receiving care in accordance with the MDD CPG, VA should

- implement processes to review data on veterans with MDD prescribed antidepressants to evaluate the level of risk of any deviations from recommended care and remedy those that could impede veterans' recovery.

To improve VA's efforts to inform its suicide prevention activities, VA should

- ensure that VAMCs have a process in place to review data on veteran suicides for completeness, accuracy, and consistency before the data are submitted to VA Central Office,
- clarify guidance on how to complete BHAP templates to ensure that VAMCs are submitting consistent data on veteran suicides, and
- implement processes to review data on veteran suicides submitted by VAMCs for accuracy and completeness.

Agency Comments

We provided a draft of this report to VA for comment. In its written comments, reproduced in appendix IV, VA generally agreed with our conclusions and concurred with our recommendations. In addition, VA provided information on its plans for implementing each recommendation, with estimated completion dates in calendar year 2015.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report's date. At that time, we will send copies of this report to the appropriate congressional committees; the Secretary of Veterans Affairs; the VA Under Secretary for Health; and other interested parties. In addition, the report will be available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions, please contact me at (202) 512-7114 or williamsonr@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report are listed in appendix V.

Sincerely yours,

Randall B. Williamson
Director, Health Care

Appendix I: Scope and Methodology

Characteristics of Veterans Diagnosed with Major Depressive Disorder (MDD)

To describe the characteristics of veterans diagnosed with MDD from fiscal years 2009 through 2013, we analyzed Department of Veterans Affairs (VA) and Department of Defense (DOD) data. (See table 3.) These data included information on veterans' demographic characteristics as well as clinical information on health care services and medications provided through VA.[1] Veterans were classified as having a diagnosis of MDD if, in at least one fiscal year included in our review, they had two or more outpatient encounters or at least one inpatient hospital stay with a diagnosis of MDD.[2]

[1]In general, veterans must enroll in VA health care to receive VA's medical benefits package, a set of services that includes hospital and outpatient services and prescription drugs. Veterans who served in the active military and who were discharged or released under conditions other than dishonorable may be eligible for VA health care. Some non-veterans may also be eligible for VA health care, such as spouses and children of veterans who have been rated permanently and totally disabled for a service-connected disability. We excluded non-veterans from our analysis.

[2]We identified this approach through discussions with VA clinical and data experts. This approach is consistent with previous GAO work. See, for example, GAO, *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, GAO-12-12 (Washington, D.C.: Oct. 14, 2011).

Table 3: Description of Department of Veterans Affairs and Department of Defense Data Files Used to Examine Characteristics of Veterans with Major Depressive Disorder for Fiscal Years 2009 through 2013

Data files	Description
Demographic files	Includes information extracted from the Department of Veterans Affairs (VA) Corporate Data Warehouse on veterans' age; date of death, if applicable; sex; race; and ethnicity. The Corporate Data Warehouse is a national data repository comprising data from several VA clinical and administrative systems. Information on whether veterans served during recent conflicts in Iraq and Afghanistan was obtained from a Department of Defense roster.
Medical SAS Inpatient Datasets, Acute Care Dataset	Includes information on acute care inpatient stays at VA medical centers (VAMC) that last at least 24 hours, including admission and discharge date as well as diagnosis codes. This dataset comprises information on inpatient care that is entered into veterans' electronic medical records by staff at VAMCs.
Fee basis inpatient files[a]	Includes information on certain acute care inpatient stays at non-VAMCs, including admission and discharge dates as well as diagnostic codes. VA pays for these stays at non-VAMCs when VA cannot offer needed care, when a non-VA provider would be economical, or on an emergency basis when travel to a VA facility is medically infeasible. The fee basis inpatient files for each fiscal year are limited to information on inpatient stays at non-VAMCs that were paid for by VA during the corresponding fiscal year.
Outpatient encounter files	Includes information on outpatient services rendered by VA providers, including the date of the services and diagnoses treated. This file comprises information on individual outpatient encounters entered into veterans' electronic medical records by staff at VA medical facilities. Encounters are defined as a professional contact between a patient and a VA provider with responsibility for diagnosing, evaluating, and treating veterans' conditions.
Fee basis outpatient services files[a]	Includes information on certain outpatient care rendered by non-VA providers, including the date of the visit and the reason for the visit. VA pays for these services from non-VA providers when VA cannot offer needed care, when a non-VA provider would be economical, or on an emergency basis when travel to a VA facility is medically infeasible. The fee basis outpatient services files for each fiscal year are limited to information on outpatient encounters that were paid for by VA during the corresponding fiscal year.
Pharmacy Benefits Management prescription database	Includes information on medications ordered by VA providers, including medication name and dosage instructions. The pharmacy database comprises information on medication orders, which are entered into local pharmacy databases by staff at VA medical facilities.

Source: GAO. | GAO-15-55

[a]The two data sets have retained the name fee basis though VA now refers to this type of care as non-VA medical care.

Specifically, we examined the following:

- **Number of veterans diagnosed with MDD**. We used a demographic file provided by VA to determine the number of veterans diagnosed with MDD.
- **Characteristics of veterans diagnosed with MDD**. We used demographic files provided by VA and DOD to describe characteristics of veterans diagnosed with MDD. In particular, the veteran characteristics we examined included the following:

  - **Age**. We created seven categories for veterans' ages as of September 30, 2013—the end of fiscal year 2013, which corresponds to the last date of data we included in our analysis. These categories are as follows: (a) 18-24, (b) 25-34, (c) 35-44, (d) 45-54, (e) 55-64, (f) 65-74, and (g) 75 and older.
  - **Era of service**. We categorized veterans as either being veterans of the recent conflicts in Iraq and Afghanistan—Operation Iraqi Freedom, Operation Enduring Freedom, and Operation New Dawn—or of other eras of service.[3]
  - **Sex**. We categorized veterans as either being female or male.
  - **Race and ethnicity**. We created categories to describe veterans' race and ethnicity (Hispanic and non-Hispanic). These categories are consistent with the Office of Management and Budget's 1997 *Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity*.[4]
- **Extent to which veterans diagnosed with MDD were prescribed at least one antidepressant**. Using data from the Pharmacy Benefits Management database, we examined the extent to which VA providers prescribed at least one antidepressant for veterans diagnosed with MDD from fiscal years 2009 through 2013. This includes antidepressants prescribed to treat depression as well as those prescribed to treat other conditions.[5]
- **The percentage of veterans with MDD dispensed a 12-week and a 6-month supply of an antidepressant**. Using VA data we obtained from the Medical SAS Inpatient Datasets, Acute Care Dataset; Outpatient Encounter Files; Fee Basis Outpatient and Inpatient

[3]We were not able to further describe veterans by other eras of service, such as Vietnam, because according to a VA official, VA data on era of service are unreliable. DOD roster data was used to determine service in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

[4]Office of Management and Budget, *Provisional Guidance on the Implementation of the 1997 Standards for Federal Data on Race and Ethnicity* (Washington, D.C.: Dec. 15, 2000).

[5]Antidepressants, like other types of medications, may be used for off-label uses—that is, for a condition or patient population for which the drug has not been approved or in a manner that is inconsistent with information found on the approved drug label. For example, certain antidepressants may be used to treat anxiety and fibromyalgia. See K.J. Stone, A.J. Viera, and C.L. Parman, "Off-Label Applications for SSRIs" *American Family Physician,* vol. 68, no. 3 (2003).

Services Files; and Pharmacy Benefits Management Database, we calculated the percentage of veterans with MDD dispensed a 12-week and a 6-month supply of an antidepressant according to statistical programming logic provided by VA.[6] These measures are intended to assess the effectiveness of antidepressant medication management and are based on performance measures developed by the National Committee for Quality Assurance.[7] In addition, these measures are consistent with the *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder*, which indicates that continued antidepressant treatment, after acute depressive symptoms have resolved, decreases the incidence of relapse of MDD.[8]

We selected six VA medical centers (VAMC) at the following locations to visit: Canandaigua, New York; Gainesville, Florida; Iowa City, Iowa; Philadelphia, Pennsylvania; Phoenix, Arizona; and Reno, Nevada.[9] These VAMCs represent different facility complexity groups, serve populations of veterans that differ in terms of the extent of use of mental health services, and are located in different Veterans Integrated Service Networks (VISN), or regional networks of care.[10] To gather additional perspectives, for each VAMC we visited, we selected one associated community-based outpatient clinic to visit. In particular, we visited community-based outpatient clinics in the following locations: Cedar Rapids, Iowa; Globe, Arizona; Gloucester, New Jersey; Lecanto, Florida; Fallon, Nevada; and Rochester, New York. (See table 4.) As part of our site visits, we

[6]VA's approach to measuring its performance on these measures uses data regarding care rendered at VA facilities only; however, in order to account for care rendered by non-VA providers but paid for by VA, we incorporated fee basis data.

[7]The National Committee for Quality Assurance's 2013 antidepressant medication management quality measures are known as Effective Acute Phase Treatment and Effective Continuation Phase Treatment.

[8]Evidence-Based Practice Work Group. *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder* (Washington, D.C.: May 2009).

[9]In contrast to the other site visits, which were completed in person, we completed the site visits to the VAMCs located in Gainesville, Florida, and Reno, Nevada, virtually through telephone interviews.

[10]VA assigns each VAMC a complexity score between 1 and 3, with level 1 being the most complex, using a facility complexity model. Level 1 is broken down further into 1a, 1b, and 1c. That model uses multiple variables to measure facility complexity arrayed along four categories, namely patient population served, clinical services offered, education and research complexity, and administrative complexity. Each VAMC is assigned to a single VISN.

reviewed a nongeneralizeable sample of five medical records for each of these six VAMCs for a total of 30 veterans.[11] We reviewed these medical records to determine if the diagnostic code entered for all encounters—starting with the initial encounter in 2012 when the veteran was diagnosed with MDD and prescribed an antidepressant—was consistent with a diagnosis of MDD.

Table 4: Characteristics of Veterans Affairs Medical Centers (VAMC) and Community-Based Outpatient Clinics Selected for GAO's Review

VAMC location	Facility complexity group, 2011	Percentage of veterans that used mental health services, 2012 (above or below average)	Veterans Integrated Service Network (VISN)	Community-based outpatient clinic location
Canandaigua, New York	3	24.6 (above)	2	Rochester, New York
Gainesville, Florida[a]	1a	22.2 (below)	8	Lecanto, Florida[a]
Iowa City, Iowa	1c	16.7 (below)	23	Cedar Rapids, Iowa
Philadelphia, Pennsylvania	1b	28.3 (above)	4	Gloucester, New Jersey
Phoenix, Arizona	1c	24.3 (above)	18	Globe, Arizona
Reno, Nevada[a]	2	22.4 (below)	21	Fallon, Nevada[a]

Source: GAO analysis of VA data. | GAO-15-55

Note: The Department of Veterans Affairs (VA) assigns each VAMC a complexity score between 1 and 3, with level 1 being the most complex, using a facility complexity model. Level 1 is broken down further into 1a, 1b, and 1c. That model uses multiple variables to measure facility complexity arrayed along four categories, namely patient population served, clinical services offered, education and research complexity, and administrative complexity. Each VAMC is assigned to a single regional network of care, called a VISN.

[a]In contrast to the other site visits, which were conducted in person, we conducted a virtual site visit via telephone interviews to these locations.

To select medical records for review, we completed the following steps:

- Randomly generated a list of individuals with a new prescription for an antidepressant in calendar year 2012.
- Selected the first five individuals in the list that met the following inclusion criteria:
  - Veteran status.
  - Had a diagnosis of MDD in calendar year 2012. For the purposes of medical record reviews, we classified a veteran as having a

[11]We use the phrase medical records to refer to electronic medical records.

diagnosis of MDD if, based on how the veteran's patient care encounters were coded or on the narrative contained in clinical notes in the veteran's medical record, the veteran had (a) at least two outpatient encounters with a diagnosis of MDD, or (b) at least one inpatient stay with a diagnosis of MDD.[12]

- Had a new treatment episode of antidepressants in calendar year 2012. New treatment episodes were defined as an initiation of antidepressant treatment following a period during which the veteran was either (1) not prescribed an antidepressant or (2) noncompliant with and had not picked up prescriptions for a previously prescribed antidepressant.

To ensure the reliability of the data we analyzed, we interviewed VA Central Office officials, reviewed relevant documentation and veterans' medical records, and conducted electronic testing to identify missing data and obvious errors. On the basis of these activities, we determined that the data we analyzed were sufficiently reliable for our purposes. However, as discussed in the report, we described limitations of the data due to the coding discrepancies we found.

VA's Oversight of the Extent to Which Veterans with MDD Prescribed Antidepressants Are Receiving Care As Recommended in the CPG

To examine the extent to which VAMCs are providing care to veterans with MDD who are prescribed antidepressants as recommended in the CPG, we reviewed relevant VA policy documents. On the basis of that review, we found that VA policy requires all care sites, VAMCs, and community-based outpatient clinics to provide evidence-based antidepressant treatment when indicated for depression and that such care must be consistent with current VA clinical practice guidelines.[13] The relevant VA clinical practice guideline, the *VA/DOD Clinical Practice Guideline for Management of Major Depressive Disorder*, provides evidence-based recommendations for providers on how to monitor veterans prescribed antidepressants; these recommendations are based on a review of depression research outcomes. These recommendations are based on available research at the time of publication of the guideline and are intended to provide information to assist providers in treatment

[12]This approach for classifying veterans as having MDD is consistent with the approach used for the purposes of our data analysis, which we identified in discussions with VA.

[13]Veterans Health Administration Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008).

decision-making.[14] From the guideline's recommendations related to monitoring veterans prescribed antidepressants, we judgmentally selected three recommendations for inclusion in our review. In particular, we selected recommendations that (1) had among the highest strength of research evidence, (2) were sufficiently specific to enable us to determine the extent to which VA providers were following the recommendation, and (3) would not require clinical judgment to determine the extent to which VA providers were following the recommendation. The following recommendations were included in our review:

- To enhance antidepressant treatment, veterans should be educated on when to take the medication, possible side effects, risks, and the expected duration of treatment, among other things;
- Standardized assessments of depressive symptoms, such as the Patient Health Questionnaire-9, should be used to monitor treatment response at 4-6 weeks after initiation of treatment, after each change in treatment, and periodically thereafter until full remission is achieved; and
- A plan should be developed that addresses the duration of antidepressant treatment, among other things.

After selecting these recommendations for our review, we examined the extent to which veterans were receiving care consistent with these CPG recommendations at the six VAMCs we visited.[15] To do this, we interviewed VAMC clinicians to determine whether and how they were following these recommendations. At each VAMC, officials interviewed included members of the executive leadership team, primary care and mental health providers, and pharmacists.[16]

[14]Although the guideline is not intended to define a standard of care, through policy, VA has set an expectation that providers follow the guideline's recommendations.

[15]For the purposes of this report, we refer to VAMCs to include community-based outpatient clinics.

[16]We also interviewed primary care and mental health providers at each community-based outpatient clinic.

Additionally, as part of our examination of the extent to which VAMCs are providing care consistent with the selected guideline recommendations, we reviewed the sample of five veterans' medical records per VAMC used as part of our review of MDD coding. For each medical record, we reviewed documentation contained in the selected veterans' medical records to assess the extent to which the antidepressant treatment-related care VA providers rendered was consistent with the selected CPG recommendations included in our review. Our review commenced with the encounter during which a VA clinician ordered an antidepressant to treat depressive symptoms. Our review ended after five follow-up encounters with a VA clinician, or sooner if the veteran did not have five follow-up encounters. Our review was limited to encounters during which the antidepressant treatment was reviewed, including encounters during which side effects and treatment effect were assessed, but no change was made to medication orders. We did not include, for example, an encounter with an orthopedist during which the fact that the veteran had been prescribed an antidepressant was simply noted. We provided the VAMCs with the instances where we found the medical record documentation was not consistent with the selected CPG recommendations. The VAMCs confirmed our answers or provided additional support if they believed the care was consistent with the CPG.

To examine VA's oversight of the care VAMCs provide to veterans with MDD who are prescribed an antidepressant, we reviewed VA's oversight of the *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook and CPG requirements and evaluated whether this oversight provides VA with adequate information to identify nonconformance with recommended practices, assess the risk of any nonconformance, and address nonconformance, as appropriate.[17] As part of this review, we reviewed VA's oversight in the context of federal standards for internal control for risk assessment.[18] The internal control for risk assessment refers to an agency's ability to comprehensively identify risks, assess the possible effect, if any, and determine what actions should be taken to mitigate significant risks.

[17]Veterans Health Administration Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008).

[18]See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999) and GAO, *Internal Control Management and Evaluation Tool*, GAO-01-1008G (Washington, D.C.: August 2001).

We then interviewed officials from VA Central Office, including officials from the Office of Mental Health Services (OMHS), the Office of Mental Health Operations, and the Office of Analytics and Business Intelligence; and the six VISNs that oversee the VAMCs we visited who are responsible for overseeing compliance with VA's requirements, including VA's requirement that all VA facilities provide evidence-based antidepressant treatment when indicated for depression and that such care be consistent with current VA clinical practice guidelines. Through our interviews, we obtained information on the oversight activities conducted by VA Central Office and the extent to which VA Central Office followed up with VAMCs to ensure that they corrected problems identified through these oversight activities. In addition, we obtained and reviewed relevant documents regarding VA oversight, including internal reports and VAMCs' plans to correct problems identified through oversight activities.

Information VA Requires VAMCs to Collect on Veteran Suicides

To analyze the information VA requires VAMCs to collect on veteran suicides, we first reviewed VA policies, guidance, and documents related to VA's suicide prevention efforts to identify the mechanisms by which VA collects veteran suicide data from VAMCs. We also interviewed VA Central Office and other officials responsible for VA's suicide prevention program, including officials from OMHS and the Center of Excellence for Suicide Prevention. We also interviewed VAMC officials and relevant staff of the six VISNs for the sites we visited to obtain information on suicide prevention initiatives.

Next, through the site visits to six VAMCs, we obtained documents and interviewed officials regarding the collection of veteran suicide data. We obtained all completed templates from the Behavioral Health Autopsy Program (BHAP) related to VA's collection of data on veterans that died by suicide as of the time of our site visit or at the time we requested the documents for virtual site visits.[19] One VAMC had not completed any of these BHAP documents because they had not had a veteran die by suicide since the beginning of the program. Therefore, our analysis includes a review of documents from five of the six VAMCs we visited. Through review of the documents, we noted any fields missing data, such as a field that requires a yes or no answer but neither answer is provided.

[19]One template had been completed as of the time of our site visit, but had not been received by VA Central Office; therefore, we did not include this template in our review.

Additionally, using professional judgment, we identified fields in the documents to review based on whether the field related to aspects of VA treatment—including treatment for mental health conditions—and the date of the veteran's death.[20] We identified these fields because they did not require clinical judgment to assess. Using the parameters in the corresponding guide for filling out these documents, including time frames, we compared these fields to information included in the veteran's medical record and noted differences between our answers and the answers provided by the VAMCs in the documents.

To ensure that we received the final, submitted versions, we also requested these documents from VA Central Office for each of the five VAMCs. We compared these documents to the documents we received from the VAMCs. We used the documents from the VAMCs as the starting point; therefore, we only analyzed the templates for veterans identified by the VAMCs.[21] During the course of our review we learned that the template for these documents had changed over time. If additional fields were included in the templates obtained from VA Central Office, but were not originally included in the templates obtained from the VAMCs, we did not review these fields. We generally used the answer from the document obtained from VA Central Office, which is the final submitted version, unless a field originally had an answer in the template from the VAMC, but was blank or not answered in the template from VA Central Office. In those cases, we used the answer from the VAMC document.

We provided the VAMCs with the fields where the answers in the VAMC's documents did not match our answers based on our review of the medical record. The VAMCs confirmed our answers or provided additional support for their original answer. Results from our review of veteran suicide data can be generalized to the VAMCs we visited, but cannot be generalized to other VAMCs.

[20]Aspects of treatment paid for by VA, but rendered by non-VA providers (non-VA care) were not included in the scope of this review.

[21]We received additional templates from VA Central Office, but these were not analyzed because the VAMC had not provided us with templates for these veterans.

We conducted this performance audit from November 2013 to November 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix II: Department of Veterans Affairs Medical Centers' Tracking of Veterans at High Risk for Suicide

The Department of Veterans Affairs' (VA) *Uniform Mental Health Services in VA Medical Centers and Clinics* handbook (Handbook) requires VA medical centers (VAMC) to have a suicide prevention coordinator whose responsibilities include establishing and maintaining a list of veterans assessed to be at high risk for suicide and monitoring these veterans.[1] The Handbook also requires suicide prevention coordinators to ensure that providers follow up on missed appointments for high-risk veterans to ensure patient safety and in order to initiate problem-solving about any tensions or difficulties in the veteran's ongoing care.

Whether a veteran is determined to be at high risk for suicide is based on clinical judgment made after an evaluation of risk factors—such as history of past suicide attempts or recent discharge from an inpatient mental health unit—protective factors—such as positive social support, positive coping skills, and positive therapeutic relationships—and the presence or absence of warning signs. Indicators that a veteran is at high risk for suicide include a current verified report or witnessed suicide attempt; identification of current serious suicidal ideation that requires an immediate change in the treatment plan, such as hospitalization; and the presence of any of the following warning signs: threatening to hurt or plan to kill oneself; looking for specific ways to kill oneself and seeking access to such means, such as pills or weapons; and talking or writing about death, dying, or suicide when these actions are out of the ordinary for the person.

The Handbook requires each VAMC to have a process for establishing a patient record flag to help ensure that veterans determined to be at high risk for suicide are provided with follow up for all missed mental health and substance abuse appointments. The primary purpose of the patient record flag is to communicate to staff that a veteran is at high risk for suicide and VA policy states that the presence of a flag should be considered when making treatment decisions. Suicide prevention coordinators are responsible for assessing, in conjunction with the treating clinician, the risk of suicide in individual veterans, ensuring these veterans have a "High Risk for Suicide" Patient Record Flag on their medical record, and reviewing the list of high-risk veterans at least every 90 days.

[1]Veterans Health Administration Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* (Sept. 11, 2008).

We interviewed suicide prevention coordinators as part of our site visits with six VAMCs to obtain information on how they track veterans determined to be at high risk for suicide. At four of the VAMCs we visited, suicide prevention coordinators used an electronic spreadsheet to track information on these veterans. For example, the spreadsheets include information such as whether the veteran has a patient record flag on their medical record and when the flag needs to be reviewed, the date for the veteran's next scheduled follow-up appointment, whether the veteran has a safety plan, and the veteran's assigned psychiatrist.[2] Officials from one VAMC told us that they maintain the list daily, adding and removing veterans as necessary. Officials stated that the circumstances under which a veteran would be removed from the spreadsheet varied, but veterans are generally removed because their patient record flag has been removed and the officials no longer consider the veteran to be at high risk for suicide.

The two remaining VAMCs use other mechanisms to track veterans at high risk for suicide. Officials from one VAMC told us that they use the Suicide Prevention Application Network (SPAN) to query high-risk patients at the VAMC. The SPAN database contains veteran information, demographic characteristics, and information on suicide attempts and completed suicides, among other things. According to officials, the information for each veteran in SPAN includes the date the veteran was assessed as being at high risk, as well as the date that the veteran needs to be seen for follow up, if applicable. After our site visit, officials told us they plan to periodically pull a list of all veterans with an active high risk flag in VA's medical record for the VAMC and cross-reference that list to veterans being tracked for high suicide risk by the suicide prevention coordinator in SPAN to ensure all high-risk veterans are tracked. Officials from the other VAMC told us that their case managers each have their own list of veterans that they track and the suicide prevention coordinator we spoke with stated that he does not keep a master list of all veterans that are at high risk for suicide.[3]

[2]A safety plan is a prioritized written list of coping strategies and sources of support, such as individuals or agencies the veteran can contact, for the veteran to use during or preceding suicidal crisis in order to help lower the veteran's imminent risk of suicidal behavior. According to VA Central Office officials, the plan is created with clinician, veteran, and family interaction.

[3]Officials at this VAMC told us that their case managers are responsible for monitoring veterans flagged as being at high risk for suicide.

Appendix III: Department of Veterans Affairs' Use of Data Related to Suicides and Suicide Behavior

Veterans Affairs medical centers (VAMC) collect and submit data on veteran suicides to the Department of Veterans Affairs (VA) Central Office through the Suicide Prevention Application Network (SPAN) and suicide behavior reports.[1] VAMCs also collect and report data through root cause analyses.[2] Additionally, VA Central Office uses the data from SPAN to prepare reports that are sent to the VAMCs and Veterans Integrated Service Networks (VISN).[3] VA Central Office officials stated that they expect VAMCs and VISNs to use these reports and collected data to improve suicide prevention efforts and program evaluation. Through site visits at six VAMCs that we conducted as part of our review and through interviews with corresponding VISN officials, we identified examples of how some VAMCs and VISNs are utilizing veteran suicide data to improve their suicide prevention efforts.

- VAMC and VISN officials have used SPAN to create initiatives based on trends in the data. For example,
  - Officials at one VAMC stated that they use the information collected in SPAN to provide data for performing statistical analyses on the outreach conducted, to study suicide attempts and completions across the VAMC catchment area, to understand the means by which veterans are dying by suicide, and to study the use of high-risk flags.
  - Officials at a VISN explained that through a review of the SPAN data about a year ago, officials learned that 60 percent of suicides in the VISN were completed using a gun. After conducting research on the subject, the VISN began a firearm safety initiative, which includes notifying veterans by mail that they can receive four gun locks each upon request, with no questions asked.

[1]SPAN includes information on veterans, such as the number of suicide completions, the number of non-fatal suicide attempts, and other indicators of suicide prevention efforts. VAMC clinicians must complete a suicide behavior report when they learn that a veteran exhibited self-harming behavior and include that report in the respective veteran's medical record.

[2]Root cause analyses are used to identify the factors that contributed to adverse events or close calls and to identify any steps VAMCs could implement to prevent similar events in the future. Root cause analyses are completed under certain circumstances, such as when the act occurs during a VAMC inpatient stay or within 72 hours of being discharged from inpatient care.

[3]VISNs are regional networks of care. Each VAMC is assigned to a single VISN.

- VAMC officials have made programmatic changes to their suicide prevention efforts based on trends in the suicide data they are collecting and reviewing. For example,
  - At one VAMC, officials told us that they reviewed suicide behavior reports and, as a result of trends identified in these reports, drafted a policy for medication restriction for veterans at risk of overdosing. Specifically, over a 3-year period, five or six veterans receiving VA care repeatedly attempted suicide by overdose, typically when they were intoxicated. VAMC officials created a work group to draft policy that mitigates risk for medication overdose among high-risk veterans. At the time of our site visit, the group was exploring creating a patient record flag that would be included in the veteran's medical record for overdose risk indicating that medication supplies should be restricted for these veterans and the possibility of using automated pill dispensers to dispense medications to these veterans.
  - Through their work reviewing suicide-related information, the suicide prevention team at another VAMC identified a trend in its suicide data. In particular, they noted that some veterans were given a 90-day supply of the same medications that the veteran recently tried to use to overdose. The suicide prevention team mentioned this to a clinical pharmacist who had also noticed this issue. The VAMC is now trying to restrict days of supply for these types of veterans, but there is no formal policy about this and no plans to craft such a policy. Additionally, officials from this VAMC stated that they have added items to the standardized suicide behavior report template to help them to collect additional useful information, such as active medications and pain score at the time of the last visit.
  - Officials from one VAMC stated that through a review of medical records and autopsy reports for veterans who died by suicide, they found that a vast majority of veterans who died by suicide were not being seen by a mental health provider. In response, officials provided education to primary care providers. VAMC officials also noticed that veterans receiving care for pain were dying by suicide at a high rate. As a result, the VAMC has started an initiative with the pain clinic, and, as part of this initiative, the chief of the pain management clinic consults with psychiatry on veterans at risk for suicide.
- Officials at a VISN described changes made in response to the suicide data in fiscal year 2012, which showed that a percentage of veterans who completed suicide had no ongoing mental health care.

These veterans mainly received care from VA primary care providers. To address this, the VISN partnered with the Center of Excellence for Suicide Prevention and local university psychologists to help VA primary care providers at community-based outpatient clinics formulate mental health plans.

Appendix IV: Comments from the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

October 21, 2014

Mr. Randall B. Williamson
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Williamson:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"VA HEALTH CARE: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Increasing Accuracy of Suicide Data"*** (GAO-15-55). VA generally agrees with GAO's conclusions and concurs with GAO's recommendations to the Department.

The enclosure specifically addresses GAO's recommendations and provides an action plan for each. VA appreciates the opportunity to comment on your draft report.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
"VA HEALTH CARE: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Accuracy of Suicide Data"
(GAO-15-55)

GAO Recommendation: The Secretary of Veterans Affairs direct the Under Secretary of Health to take the following six actions:

To more accurately estimate the prevalence of MDD and identify enrolled veterans with MDD, VA should

Recommendation 1: identify the extent to which there is imprecise diagnostic coding of MDD by further examining encounters with a diagnostic code of depression not otherwise specified, which could be incorporated into VAMCs' ongoing review of diagnostic coding accuracy.

VA Comment: Concur. The Department of Veterans Affairs (VA) agrees that precise and reliable diagnoses are an important guide to treatment planning. The Veterans Health Administration (VHA) will examine patterns of diagnostic coding among VHA patients with new episodes of depression treatment by evaluating diagnosis patterns and treatment settings. This will include examination of the available data regarding structured assessments for depression Population Health Questionnaire (PHQ) scores in association with diagnostic specificity and treatment settings. For example, VA may expect that initial assessments performed in primary care settings are coded with less specificity, relative to follow-up assessments conducted in mental health clinic settings. Target Completion Date: January 2015.

Recommendation 2: determine and address the factor(s) contributing to the imprecise coding based on the results of those examinations. For example, feedback and additional training could be provided to clinicians regarding the importance of diagnostic code accuracy, or VA's medical record could be enhanced to facilitate the selection of a more accurate diagnostic code.

VA Comment: Concur. In addition to the analyses described above in Recommendation 1, VA will conduct focused chart reviews to evaluate whether further information regarding the care processes and clinical communications may help to explain changes in diagnostic specificity among individuals who at some point receive Major Depressive Disorder (MDD) diagnoses. VHA will consult with a sample of treatment providers in primary care and in mental health clinic settings to analyze VHA's understanding of diagnostic code selection and to develop steps to enhance diagnostic coding practices.

In part, future actions are dependent on the findings associated with Recommendation 1. However, identification and correction of factors contributing to imprecise coding was initiated based upon the findings of the GAO review of 30 records. Informatics staff initiated a national review of the encounter forms for Mental

1

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
"VA HEALTH CARE: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Accuracy of Suicide Data"
(GAO-15-55)

Health appointments and identified the software mapping error in the diagnosis search feature that was referenced in the report. Steps have been taken to correct this mapping error, and VHA expects that this fix will be deployed to the field in November 2014. Additionally, in September 2014 both Mental Health and Health Information Management Service staff in the field were notified via email distribution and conference calls regarding this software error. If additional coding reviews reveal further coding inaccuracies, a plan will be developed to determine and address the factors contributing to coding variance from the diagnosis supported in the documentation of the progress note. Target Completion Date: March 2015.

To ensure that veterans are receiving care in accordance with the MDD CPG, VA should

Recommendation 3: implement processes to review data on veterans with MDD prescribed antidepressants to evaluate the level of risk of any deviations from recommended care and remedy those that could impede veterans recovery.

VA Comment: Concur. Using the available measures of antidepressant treatment practices (e.g., the Healthcare Effectiveness Data and Information Set) measure of adequate antidepressant continuation following a new antidepressant start, VHA will examine associations between treatment practices and indicators of Veteran recovery and/or adverse outcomes. This will include assessing changes in PHQ scores, as available, as well as associations with potential adverse outcomes such as inpatient psychiatric admissions. VA notes that such analyses are complicated by potential confounds (e.g., greater treatment receipt among patients with greater severity, with severity also associated with greater likelihood of negative outcomes). Future actions will be informed by the aforementioned analysis. Target Completion Date: March 2015.

To improve VA's efforts to inform its suicide prevention activities, VA should

Recommendation 4: ensure that VAMCs have a process in place to review data on veteran suicides for completeness, accuracy, and consistency before the data are submitted to VA Central Office.

VA Comment: Concur. This is data that frequently changes as more data become available. The information is all submitted to the Center of Excellence for Suicide Prevention (CoE) as it becomes available and there is the ability to change the data once it is submitted. Delaying the submission until it is complete would result in several non-entries. Therefore, sites are encouraged to submit what they have when it is available. In the future, the CoE will ask for verification of review by facility leadership of all submissions during the previous 6 months prior to analyzing or rolling up the data.

2

Enclosure

Department of Veterans Affairs (VA) Response to
Government Accountability Office (GAO) Draft Report
"VA HEALTH CARE: Improvements Needed in Monitoring Antidepressant Use for Major Depressive Disorder and in Accuracy of Suicide Data"
(GAO-15-55)

The CoE will create an initial box on the chart review form that will acknowledge this has been completed at the facility level. Target Completion Date: June 2015.

Recommendation 5: clarify guidance on how to complete BHAP templates to ensure that VAMCs are submitting consistent data on veteran suicides.

VA Comment: Concur. New guidance has been incorporated into the Suicide Prevention Coordinator (SPC) Guidebook and it was redistributed to the field. In addition, a Frequently Asked Question sheet was developed and sent to the field in September 2014 (Attachment A), and CoE staff will be present on monthly SPC calls to respond to any questions and needs.

Recommendation 6: implement processes to review data on veteran suicides submitted by VAMCs for accuracy and completeness.

VA Comment: Concur. A software program is being written to compare Chart Reviews from the Behavioral Health Autopsy Program to the Suicide Prevention Access Network data on a monthly basis. If there are differences in who submitted them, the information will be pulled and returned to the SPC for clarification. In addition, all submissions will be reviewed for completeness 3 months after submission and returned for clarification, if needed, prior to any analysis or roll up of the data. This will be completed prior to facility leadership review. Target Completion Date: December 2015.

3

STRENGTHENING DEPARTMENT OF HOMELAND SECURITY

Chairman Johnson, Ranking Member Carper, and distinguished Members of the Committee:

Thank you for the opportunity to submit this Statement for the Record regarding the 2015 Government Accountability Office (GAO) High Risk List. Secretary Johnson and I appreciate this Committee's interest in this important issue.

We are grateful to GAO for the valuable oversight they exercise. It is my firmly-held belief that good oversight not only delivers accountability critical to good government, but that it also drives innovation. We have benefited greatly from GAO's hard work to help us improve, and continue to do so as we work regularly with GAO to address the Department of Homeland Security's (DHS) presence on the High Risk List.

When I became the Deputy Secretary of DHS in late December 2013, the first action I took was to schedule a meeting with Comptroller General Dodaro. I committed early on to engage with GAO frequently, with the intention of not only getting off the GAO High Risk List but also to set the standard within the Federal Government for how to engage with and learn from GAO and its dedicated team of experts. I am proud of the progress we have made, demonstrating significant improvements in several High Risk List areas, and also serving as a model for collaboration and partnership with GAO. We will continue to seek out GAO and work together to improve this Department.

Strengthening Department of Homeland Security Management Functions

Upon its creation in 2003, DHS was immediately placed on the GAO High Risk List because of the challenge of bringing together 22 disparate federal entities and the very serious consequences of another attack on our Nation. In each subsequent GAO High Risk List report, DHS has demonstrated significant and constant progress. When the last High Risk List was issued in 2013, GAO narrowed this High Risk List category significantly. Now titled "Strengthening Department of Homeland Security Management Functions," GAO stated that DHS's approach, "if implemented and sustained, provides a path for DHS to be removed from GAO's High Risk List."

Throughout our first year at DHS, Secretary Johnson and I have committed ourselves fully to making meaningful progress in addressing this High Risk area, with the ultimate goal of removal from the high risk designation. We have taken extraordinary steps in the areas of financial management, human capital management, acquisitions, and information technology with that goal in mind, including receipt of a clean audit opinion of the Department's financial statements, a significant accomplishment. We developed monthly action plans with measurable targets to address GAO recommendations, and we share those action plans regularly with GAO. The number of open GAO recommendations to DHS has decreased steadily.

We have enhanced, strengthened, and integrated our management lines-of-business not simply because of the High Risk list, but also because it is critical to the Secretary's vision embodied in the Department's Unity of Effort initiative, which aims to execute our missions in such a way that best utilizes our limited resources.

Financial Management

In FY 2014, DHS earned a clean audit opinion on the agency's financial statements for the second consecutive year. Sustaining a clean audit opinion is the result of strong policies, procedures, and controls that are in place throughout the financial management community at DHS. The audit findings demonstrate that DHS can accurately account for and report on its resources. DHS also significantly improved internal controls by completing substantial property accounting remediation at the U.S. Coast Guard. At ICE and USCIS, the audit found improved information technology controls and removed that issue from the report. This positions DHS for a clean internal control audit in FY 2016.

Financial systems modernization is critical to sustaining progress in maturing financial management at DHS and maintaining a clean audit opinion. Modernizing will help address areas such as systematic internal control weaknesses, audit readiness and sustainability, and improve the Department's ability to effectively and efficiently process and report financial data. In addition, Components comply with standard operating procedures on managing financial systems modernization (e.g. schedule, monitoring and mitigating risk, capturing lessons learned for future use.

Moving forward, DHS will continue to make improvements, identify and commit resources to remediate remaining material weaknesses, and continue to fully modernize financial systems to improve data reliability, availability, and accuracy.

Human Capital Management

Our dedicated employees are the backbone of our organization and I have committed a significant amount of time and energy to engage with DHS employees. For example, I have participated in several focus groups with employees to engage in honest conversations about what is working across the Department and what areas can realistically be improved. One priority area is to ensure that our hiring, promotion and performance management processes are fair and transparent. I will continue to engage with both our employees and managers to directly address and remediate morale issues.

GAO has provided positive feedback on the latest Human Capital Strategic Plan, which unifies the Department on critical goals, outcomes and measures to continuously improve the way we hire, develop and reward our workforce. This Plan serves as the cornerstone to drive success across the Department.

Acquisition Program Management

While we have made progress in the acquisition area, we know that we have much work yet to do. We are encouraged by the maturation of the reconstituted Joint Requirements Council as it works to assess joint requirements for several investment portfolios, which include: information-based screening and vetting, aviation commonality, information sharing, chemical-biological-radiological-nuclear programs, and cybersecurity efforts. In the past year, we have improved acquisition oversight by solidifying the Component Acquisition Executive structure, ensuring that qualification and training standards are clear for program managers within the Components.

To ensure that all of our acquisition programs are adequately staffed to support the Department's mission, we now require all Component Acquisition Executives and major programs to submit staffing plans and three-year workforce planning documentation. Additionally, we continue to cultivate talent through the Acquisition Professional Career Program as 60 students graduated in 2014 and they have been placed throughout Components in both contracting and program related positions. These interns are home-grown talent and are positioned to become the acquisition leaders of the future.

The Department's Acquisition Review Board increased the frequency of its program reviews in FY 2014, averaging more than one major program review per month. In FY 2014, we prepared a new Systems Engineering Lifecycle Instruction and Guidebook, and our Director of Operational Test and Evaluation initiated a project to improve the timing, quality, and content of program Test and Evaluation Master Plans. Also, as a proactive measure to identify and address issues before they become critical, DHS implemented a monthly High-Visibility Briefing of the Department's major acquisition programs for the Chief Acquisition Officer (CAO) and Acquisition Review Board members. In FY 2015, we will further strengthen acquisition oversight by implementing more effective metrics to track policy compliance, program health, cost, schedule, and performance of major programs. This additional layer of oversight will enable the Department to apply data-driven evaluations to identify weaknesses and apply targeted remediation.

Information Technology Management

The Department is committed to strengthening information technology management and has either fully or mostly addressed four of six information technology management outcomes. For example, our continued commitment to strengthening Information Technology security is reflected by a compliance rate of 95% for the provisions of the Federal Information Security Management Act. In addition, we have adopted the continuous diagnostics and mitigation approach, which will allow Components to identify, fix, and report their most critical cyber problems on a near-real time basis. Lastly, we implemented intrusion monitoring to help the Department assess the overall effectiveness of specific network defense systems.

Strong Information Technology governance structures and processes ensure more efficient and effective management of technology investments. By aligning our technology investments to capability-based portfolios, establishing five new program-level Executive Steering Committees, the Department has

strengthened its governance structure. Additionally, we conducted our annual portfolio reviews, which informed budget development for FY 2016.

Further, the Management Cube, a new Department-wide business intelligence tool developed by our dedicated DHS employees, is beginning to be used to inform critical decisions. This tool incorporates business data into a common platform, enabling analysis that links dollars, people, assets, contracts, and programs. We will work unceasingly in the coming year to build upon this progress.

National Flood Insurance Program

The National Flood Insurance Program (NFIP) is a key component of the Federal Government's efforts to limit the damage and financial impact of floods; however, it will not generate sufficient revenues to repay the billions of dollars borrowed from the U.S. Department of the Treasury to cover claims from the 2005 hurricanes or future catastrophic losses. The lack of sufficient revenues highlights structural weaknesses in how the program is funded. The Federal Emergency Management Agency (FEMA), within DHS, is responsible for managing the NFIP. FEMA has taken steps to remediate weaknesses in NFIP management and operations, including financial reporting processes and internal controls and oversight of contractors that placed the program at risk. Additionally, Hazard Mitigation Assistance grants provide funding to enhance a community's resilience to flooding. And finally, the President's Climate Action Plan (June 2013) required agencies to revise their flood risk standards. To further this goal, an Executive Order Establishing a Federal Flood Risk Management Standard was announced January 30, 2015. While not directly linked to the NFIP, it will result in structures in flood-prone areas being more resilient. This will help strengthen the overall solvency of the program .

FEMA continues to make progress on the National Flood Insurance Program and to address structural and operating challenges. The Biggert-Waters Flood Insurance Reform Act of 2012 (Biggert-Waters Act) and the Homeowner Flood Insurance Affordability Act of 2014 (HFIAA) introduced many changes to NFIP. In particular, the Biggert-Waters Act eliminated subsidized premium rates for several types of properties. As mandated by the Biggert-Waters Act, FEMA has begun phasing out subsidies on policies for residential properties that are not primary residences, and single-family properties with severe repetitive losses. However, in March 2014, Congress passed and the President signed into law HFIAA, which altered portions of the Biggert-Waters Act. FEMA has worked to implement sections of the Homeowner Affordability Act that repealed certain rate increases and set new requirements for rate increases and continues to examine affordability issues through the Affordability Study required by both Acts.

FEMA continues to work closely with GAO to address the operating challenges identified in GAO's recommendations to improve management and operations. GAO undertook several engagements in 2014 that resulted in recommendations, that when implemented will improve FEMA's oversight of the NFIP. FEMA already implemented several recommendations and looks forward to working with GAO to close these recommendations.

Establishing Effective Mechanisms for Sharing and Managing Terrorism-Related Information to Protect the Homeland

The Department of Homeland Security (DHS) continues to be committed to its obligations to share information with the Intelligence Community (IC) partners for national security purposes and to ensure that the data shared is appropriately used, maintained, and protected by our IC partners. To that end, DHS finalized its bulk data sharing policy for counterterrorism purposes. DHS identified a framework of six factors (consisting of both data sensitivity and operational factors) to be considered in determining periods of retention by the IC of bulk-ingested DHS datasets. This framework was the cornerstone for the renegotiation of DHS datasets concerning the National Counterterrorism Center (NCTC) revised Attorney General Guidelines. DHS, in partnership with NCTC, was able to complete Memoranda of Agreements for the following DHS datasets:

- Advanced Passenger Information System (APIS);
- Refugees, Asylum, and Parole System (RAPS);
- Arrival and Departure Information System (ADIS); and
- Electronic System for Travel Authorization (ESTA).

DHS is also championing the DHS Data Framework, a scalable technology program; the pathway to building better data aggregation and information sharing systems, and incorporating privacy, civil rights and civil liberties protections into the data and system architecture, while enabling better controlled, more effective, and more efficient use of existing homeland security-related information across the DHS enterprise and with other U.S. Government partners, as appropriate.

DHS continues to mature its information sharing network with our State, Local, Tribal, and Territorial (SLTT) partners. In support of these information sharing efforts, DHS Office of Intelligence and Analysis (I&A) continues to leverage the Homeland Security Information Network (HSIN) as its primary platform to share unclassified information with these partners, and facilitate real-time collaboration on a host of topics ranging from joint production to the provision of real-time situational awareness. In particular, I&A shares unclassified intelligence information with SLTT partners via the HSIN-Intelligence (HSIN-Intel) community of interest. HSIN-Intel provides intelligence professionals with a secure platform for effective and efficient collaboration, access to data, analytical exchange, and timely information sharing and situational awareness. Additionally, I&A manages the joint DHS and Federal Bureau of Investigation (FBI) Countering Violent Extremism and Active Shooter (CVE-AS) Web Portal. This portal, also located within HSIN, provides users and training practitioners with accurate, appropriate, and relevant CVE and AS training development resources, subject matter expert contact information, and information on outreach and engagement initiatives.

The resources provide a great example of the tools DHS has implemented to minimize gaps in sharing relevant and timely information and intelligence concerning threats to the homeland with its customers.

Protecting the Federal Government's Information Systems and the Nation's Cyber Critical Infrastructures

The Department has made significant progress in improving its ability to protect against cyber threats by advancing its cyber analysis and warning capabilities, acquiring enhanced analytical and technical capabilities, developing strategies for hiring and retaining highly qualified cyber analysts, and strengthening the effectiveness of its public-private sector partnerships in securing cyber critical infrastructure.

Executive Order 13636 on Cybersecurity and Presidential Policy Directive 21 on Critical Infrastructure Security and Resilience takes a whole-of-government approach and reinforces the need for holistic thinking about security and risk management across critical infrastructure sectors. More specifically, the whole-of-government approach is a result of the Executive Order directing the Secretary of Homeland Security to establish a consultative process to coordinate improvements to the cybersecurity of critical infrastructure (Sec. 6). This approach also resulted in the interagency taskforce, led by DHS, to include representatives from Sector-Specific Agencies, other relevant agencies, independent regulatory agencies, the law enforcement community, the National Institute of Standards and Technology, and the Intelligence Community. DHS met each of its deadlines under these directives, including publication of the revised National Infrastructure Protection Plan and establishment of the Critical Infrastructure Cyber Community (C-Cubed) Voluntary Program.

Since the beginning of Fiscal Year 2014, DHS has closed 11 Government Accountability Office (GAO) and 18 Office of Inspector General (OIG) recommendations directed at DHS's National Protection and Programs Directorate's Office of Cybersecurity and Communications. Included in those recommendations, DHS closed out OIG-13-95, *DHS Can Take Actions to Address Its Additional Cybersecurity Responsibilities*, which was highlighted in the 2014 GAO High-Risk Series Discussion Draft. DHS has also implemented all recommendation issued in OIG-14-52, *Implementation Status of EINSTEIN 3 Accelerated (E^3A)* and OIG-14-119, *Implementation Status of Enhanced Cybersecurity Services (ECS)*. While recommendations remain open, DHS has demonstrated progress in implementing recommendations and working with GAO and OIG to ensure a mutually beneficial partnership.

Conclusion

The women and men of the Department of Homeland Security dedicate themselves each day to improving our Department, and making important advances on the areas enumerated in GAO's High Risk List. The progress we have made as a Department are a direct result of these efforts. I pledge to this Committee our resolve that we will re-commit ourselves to working closely with GAO and re-doubling our efforts to make progress on these important areas, in order to make DHS eligible for removal from the GAO High Risk List.

(A)

Table 1: Status of Actions Directed to Congress and the Executive Branch in Our 2011-2014 Annual Reports, as of November 19, 2014

	Executive branch[a]		Congress[b]		Grand totals	
Status	Number of actions	Percentage	Number of actions	Percentage	Total number of actions	Overall percentage
Addressed	116	30%	19	26%	135	29%
Partially addressed	189	49	13	18	202	44
Not addressed	66	17	37	50	103	22
Consolidated or other	13	3	5	7	18	4

Source: GAO. | GAO-15-440T

Note: In assessing actions suggested for Congress, we applied the following criteria: "addressed" means relevant legislation has been enacted and addresses all aspects of the action needed; "partially addressed" means a relevant bill has passed a committee, the House of Representatives, or the Senate, or relevant legislation has been enacted but only addressed part of the action needed; and "not addressed" means a bill may have been introduced but did not pass out of a committee, or no relevant legislation was introduced. In assessing actions suggested for the executive branch, we applied the following criteria: "addressed" means implementation of the action needed was completed; "partially addressed" means the action needed was in development, or started but not yet completed; and "not addressed" means the administration, the agencies, or both made minimal or no progress toward implementing the action needed. Actions included in "consolidated or other" were not assessed due to additional work or other information we considered.

[a]Executive branch agencies took steps that addressed four actions directed to Congress.

[b]Congress took steps that fully addressed one action and partially addressed another action directed to executive branch agencies.

Post-Hearing Questions for the Record
Submitted to the Honorable Gene L. Dodaro
From Senator Joni Ernst

"Risky Business: Examining GAO's 2015 List of High Risk Government Programs"
February 11, 2015

1. **Modernizing the U.S. Financial Regulatory System and the Federal Role in Housing Finance**

    a. **From your review, outside the legislative landscape, are there steps FHFA could be taking to improve the system?**

Our focus in this area has been on evaluating options for restructuring Fannie Mae and Freddie Mac (the enterprises)—which FHFA placed under conservatorship in 2008—and the federal role in housing finance generally. In a 2009 report, we provided a framework for identifying trade-offs associated with options for revising the long-term structures of the enterprises.[1] In a 2014 report, we provided a framework to help reveal the relative strengths and weaknesses of proposals to change the housing finance system and to identify what are likely to be significant trade-offs among competing goals and policies.[2]

In addition to facilitating any restructuring of the enterprises and the oversight of housing finance entities, it will be important for FHFA to follow through on key efforts it has under way to help improve the housing finance system. For example, in 2012, FHFA directed Fannie Mae and Freddie Mac (the enterprises) to develop a new mortgage securitization platform that would replace the enterprises' proprietary systems and that could be used by multiple securities issuers. FHFA will need to continue to oversee this effort to ensure that remaining development and implementation challenges are addressed. In addition, FHFA has an ongoing initiative with Consumer Financial Protection Bureau (CFPB) to build a national mortgage database. Completing this effort is important because the database could be a useful tool for examining the effect of reforms to the housing finance system. Further, under FHFA's direction, the enterprises have executed transactions that share single-family mortgage credit risk with private market participants. Because these transactions could help inform the development of standards for future mortgage securitizations, FHFA will need to follow through on efforts to assess the merits of the transactions. We will continue to monitor the actions of FHFA and other federal agencies with key roles and responsibilities in the housing finance system.

    b. **You referenced that "FHA's Mutual Mortgage Insurance Fund has been out of compliance with its statutory 2-percent capital requirement since**

---

[1]GAO, *Fannie Mae and Freddie Mac: Analysis of Options for Revising the Housing Enterprises' Long-term Structures,* GAO-09-782 (Washington, D.C.: Sep. 10, 2009).
[2]GAO, *Housing Finance System: A Framework for Assessing Potential Changes,* GAO-15-131 (Washington, D.C.: Oct. 7, 2014).

fiscal year 2009." What recommendations do you have to ensure compliance? Should there be consequences for not complying? Are their actions FHA could be taking outside of legislative action to improve this ratio?

In a 2010 report on FHA's financial condition, we noted that the Omnibus Budget Reconciliation Act of 1990 requires FHA to maintain a capital ratio of at least 2 percent "at all times" after November 2000 but does not specify time frames for reattaining a 2 percent ratio should it fall below that level.[3] We concluded that in the absence of more explicit directions, the priority that FHA should place on restoring the capital ratio versus its operational goals (for example, providing mortgage insurance to traditionally underserved borrowers) may be unclear. As a result, we suggested that Congress consider establishing a minimum time frame for restoring the capital ratio to 2 percent should the ratio fall below that level, taking into account FHA's statutory operational goals and role in supporting the mortgage market during periods of economic stress.[4] Additionally, in 2013, we suggested that Congress consider requiring FHA to submit a capital restoration plan whenever the capital ratio falls below 2 percent in order to strengthen FHA accountability for complying with the capital requirement.[5]

Further, we previously recommended that Congress or FHA specify the economic conditions that FHA's insurance fund would be expected to withstand without drawing on the Treasury.[6] FHA has not implemented this recommendation, but has adopted a methodology known as stochastic simulation to better incorporate the variability of economic variables into estimates of the insurance fund's capital ratio. While we have not recommended specific actions that FHA should take to improve the capital ratio, in a 2013 report, we examined a number of proposed options to help improve FHA's long-term viability, including adjustments to the terms and conditions of FHA's insurance products and changes to FHA's structure and powers.[7]

---

[3]GAO, *Mortgage Financing: Opportunities to Enhance Management and Oversight of FHA's Financial Condition,* GAO-10-827R (Washington, D.C.: Sept. 14, 2010).
[4]Legislation that would have established a minimum time frame was introduced in the 112th Congress (2011-2012) but was not enacted. See *FHA Bailout Protection Act of 2011* (S. 1997).
[5]GAO, *FHA Mortgage Insurance: Applicability of Industry Requirements Is Limited, but Certain Features Could Enhance Oversight,* GAO-13-722 (Washington, D.C.: Sep. 9, 2013). Legislation that would have required FHA to develop an emergency capital plan was introduced in 2012 and 2013 but was not enacted.
[6]GAO, *Mortgage Financing: FHA's Fund Has Grown, but Options for Drawing on the Fund Have Uncertain Outcomes,* GAO-01-460 (Washington, D.C.: Feb. 28, 2001). Legislation consistent with our recommendation was introduced in the 107th Congress (2001-2002) but was not enacted. See *Housing Affordability for America Act of 2002* (H.R. 3995).
[7]GAO, *Federal Housing Administration: Analysis of Options for Modifying Its Products, Market Presence, and Powers,* GAO-13-682 (Washington, D.C.: Sept. 9, 2013).

c. Are current policies at FHFA that aim to expand the role of the federal government in housing finance exacerbating the overall risk profile?

We have not evaluated the potential impact of FHFA's current regulatory policies on overall risks. However, we have previously indicated that interactions between the different parts of the housing finance system need to be considered in assessing risks to the federal government. For example, in our 2013 High-Risk Update, we stated that efforts to reduce the market presence of the enterprises could shift some borrowers currently served by that market segment to FHA.[8] (Conversely, FHFA policies with the potential to expand the enterprises' market presence could shift some borrowers away from FHA.) We further noted that regulations required by the Dodd-Frank Wall Street Reform and Consumer Protection Act will have major implications for the size and borrower composition of the private-label market for mortgage-backed securities, which, in turn could affect the risk exposure of the enterprises and FHA. Additionally, in a 2014 report, we discussed the view of some stakeholders that reforming one part of the housing finance system, such as the secondary market, could create additional risks elsewhere in the system, such as in the primary market.[9]

2. Managing Federal Real Property

a. Does GAO have recommendations on how to make the disposal process more efficient, less-time consuming and less costly? Is it your understanding that the Office of Management and Budget (OMB) will include these recommendations in their upcoming national real property strategy?

We have made a number of recommendations to improve the identification and disposal of unneeded federal real property. In recent years, our focus has been on improving planning and real property data. Specifically, the Office of Managment and Budget (OMB), in conjunction with land-holding agencies, could improve its capacity by implementing our 2012 recommendation to develop a strategic plan for managing excess and underutilized real property.[10] We also continue to believe that consistent and accurate data on federal real property are necessary for the federal government to effectively manage real property. However, we found in 2012 that the federal real property database may not be a useful tool for describing the nature, use, and extent of excess and underutilized federal real property.[11] We recommended that the General

[8]GAO, *High-Risk Series: An Update,* GAO-13-283 (Washington, D.C.: February 2013).

[9]GAO, *Housing Finance System: A Framework for Assessing Potential Changes,* GAO-15-131 (Washington, D.C.: Oct. 7, 2014).

[10]GAO, Federal Real Property: National Strategy and Better Data Needed to Improve Management of Excess and Underutilized Property, GAO-12-645 (Washington, D.C.: Jun. 20, 2012).

[11]GAO-12-645.

Services Administration's (GSA) work with other land-holding agencies to improve governmentwide real property data, consistent with sound data collection practices, so that the data collected are sufficiently complete, accurate, and consistent. OMB released the National Strategy for the Efficient Use of Real Property on March 25, 2015. The strategy lays out the Administration's plans to freeze growth in inventory, measure performance through data-driven decision making, reduce the size of the inventory through consolidation, co-location, and disposal of properties. We will thoroughly review the plan and its implementation.

b. Your report states, "The Federal government continues to rely heavily on leasing of properties where it would be more cost efficient for the federal government to own...in 2013 we found that high-value leases account for over one third of GSA's annual rent paid to private sector landlord and more than a quarter of the total lease square feet while representing just 3 percent of GSA leases." If it is more cost efficient to own a property, why are agencies continuing to rely on leasing?

We have found that operating leases are appropriate for some real property requirements, such as those with short-term needs. However, GSA officials said that most of the high-value leases consist of long-term, relatively stable, mission-central needs for federal agencies—space needs that in many cases are likely to exist for longer than 20 years—and that in these cases, ownership is the most cost-effective solution over time. GSA officials stated that limited funding for its capital program has given GSA no choice but to continue to lease space for these government needs. Budget scoring rules require that the full cost of a capital purchase must be recorded in the year in which the budget authority is to be made available. In contrast, because operating leases are intended for short-term needs, only the amount needed to cover the first year's rent and any cancellation costs need to be recorded in the budget in that year. We have also found that the lack of upfront capital for reconfiguration and renovation also creates challenges for the consolidation from privately-leased space into underutilized federally-owned space.[12]

c. In 2012, the Acting Director of OMB, Jeffrey Zients, issued a memorandum stating that "agencies shall not increase the size of their civilian real estate inventory" and "any acquisition of new federal building space...that increases an agency's total square footage of civilian property must be offset through consolidation, co-location, or disposal of space from the inventory of that agency." To your knowledge, has this guideline been followed?

[12]GAO, Capital Financing: Alternative Approaches to Budgeting for Federal Real Property, GAO-14-239 (Washington, D.C.: Mar, 12, 2014).

To date, a lack of reliable real property data makes the answer to this question unclear; in 2015 we examined data from four of the six agencies that made the largest reductions in the first year of Freeze the Footprint reporting and found the data were not reliable, and we found that some of the largest reductions were overstated.[13] In addition, OMB reported that 9 of 24 agencies saw a net increase in square footage between FY 2012 and FY2013, the only year of Freeze the Footprint reporting available to date. However, agency officials told us that some of the changes impacting the results of the first year of Freeze the Footprint policy were the result of efforts underway before the policy began. Officials at each of the four agencies we interviewed also said, however, that the Freeze the Footprint Policy is an incentive to reduce office and warehouse space going forward.

d. In your report you also mention that much of the data and results generated from the Freeze the Footprint policy were "not reliable" and that results in many agencies were "overstated." Understanding that mistakes happen or that assumptions can be misleading, are there consequences for agencies that provide false or inaccurate information on real property and fail to follow the guidance from the Federal Real Property Council? Should there be incentives to encourage the disposal of excess or underutilized property?

In our review, we did not find any circumstances in which an agency had knowingly provided false or inaccurate information. Rather, the overstated reductions in square footage we identified were due to factors including the timing of when the reporting baseline was set, the categorization of space to another use, the correction of data errors, or the transfer of properties to GSA. Additionally, we found in past work that the current definitions of certain data elements could perpetuate confusion regarding the nature of federal government properties. Although some agency officials have told us during prior reviews that agency disposal costs can outweigh the financial benefits of property disposal and that limited budgetary resources create a disincentive to property disposal, property disposal carries with it the ongoing benefit of avoiding costs to operate, maintain, and secure unneeded real property assets. The consequences of unreliable data are significant: government managers are unable to effectively manage real property or measure the effectiveness of reforms, such as the Freeze the Footprint initiative.

e. Does the agency have an accurate figure on how much money the government is wasting in underutilized federal real property?

[13]GAO, High-Risk Series: An Update, GAO-15-290 (Washington, D.C.: Feb, 11, 2015).

We have not been able to estimate this number because of reliability issues with the federal government's real property data. In our 2012 report, we found that the Federal Real Property Council—an association of federal land-holding agencies—has not followed sound data collection practices in designing and maintaining the governmentwide real property database, raising concern that the database is not a useful tool for describing the nature, use, and extent of excess and underutilized federal real property. For example, we found that the agencies we reviewed did not report property initialization consistently. Specifically, we found utilization data inconsistencies or inaccuracies for properties at 19 of the 26 federal sites we visited. For example, we found two buildings at a U.S. Department of Agriculture site that were listed as "utilized" from 2009 to 2010 but were in fact vacant.

2. **DOD Contract Management**

   a. **In your report you state, "DOD has also completed competency assessment that identified the current skills and capabilities of the acquisition workforce and helped identify areas needing further management attention. In that regard, in areas such as cost estimation and systems engineering, our work found that DOD may not have adequate resources to fully implement recent weapon system reform initiatives." Please elaborate on these specific weapon system reforms that are at risk. In addition, can you provide information on this area's current capabilities?**

The Weapon Systems Acquisition Reform Act of 2009 established new offices within the Office of the Secretary of Defense to, among other things, oversee acquisition program office efforts related to developmental testing, systems engineering, and cost estimating, and serve as an advisor to the Under Secretary of Defense for Acquisition, Technology and Logistics on these activities. We reported in December 2012 that leaders from the Developmental Test and Evaluation and the Cost Assessment and Performance Evaluation offices told us that they had implemented most of the fundamental Reform Act provisions, but they had to limit their activities to a portion of acquisition programs in their portfolios due to resource constraints.[14] Thus, it was doubtful that they could expand the scope of their activities to include more weapon acquisition programs at current staffing levels. For example,

- The Developmental Test and Evaluation Office had to be selective in its level of oversight of acquisition programs because office staffing, which included about

[14]GAO, *Weapons Acquisition Reform: Reform Act Is Helping DOD Acquisition Programs Reduce Risk, but Implementation Challenges Remain,* GAO-13-103 (Washington, D.C.: Dec. 14, 2012).

70 government and contractor personnel, could not adequately cover a portfolio of over 200 acquisition programs, according to its Deputy Assistant Secretary. The office had dropped virtually all but the largest programs from its oversight list and eliminated oversight of some major automated information systems.

- Cost Assessment and Performance Evaluation officials estimated that its cost assessment division would need to double in size to meet the Reform Act's requirements. However, soon after the Reform Act was enacted, budgetary constraints limited the expansion of the cost estimating workforce to about 25 percent of the necessary growth. Officials from that office stated that its cost analysis staffing at the time of our review was not adequate to meet its mission of improving the analytical skills of the defense cost estimating workforce, issuing policy, and providing sound and unbiased cost and schedule estimates. The office had delegated its independent cost estimating responsibility for most major automated information systems to the military services and some guidance had yet to be issued.

- The Systems Engineering office was also struggling in some regards. For example, according to its Deputy Assistant Secretary, the Systems Engineering office was continuously challenged to maintain the high caliber, qualified personnel required to provide assistance to and oversight of its portfolio of over 200 acquisition programs.

We also reported that it was unclear whether the services had a sufficient number of qualified personnel to conduct systems engineering and test and evaluation activities. For example, the Deputy Assistant Secretary for Systems Engineering reported to Congress in March 2012 that the Army has reduced its systems engineering workforce growth plan as compared to the plan reported in March 2011, and that contractor-to-civilian conversions have been suspended. In addition, the Deputy Assistant Secretary believed a prolonged hiring freeze in the Air Force could potentially create new experience gaps in the workforce.

Statistics provided by the Department of Defense's (DOD) Human Capital Initiative office show that as of the end of fiscal year 2014, the engineering and business career fields, which include the systems engineering and cost estimating workforces, respectively, have both increased in size since 2008. Specifically, between fiscal years 2008 and 2014, the engineering career field grew from 34,537 to 39,242, a 14 percent increase; and the business career field grew from 7,085 to 7,451, a 5 percent increase. We are conducting a review of DOD's acquisition workforce to determine if there are any skill or capability gaps in these areas.

b. Your report also mentions that DOD has delayed issuance of a strategic plan specific to its acquisition workforce and has not issued its biennial plan since April 2010. What is the reasoning for this delay?

We are mandated to review and report on DOD's acquisition workforce plan within 180 days of its issuance. We have been in contact with DOD's Human Capital Initiatives Office since its previous report was issued in April 2010. DOD had planned to issue an updated strategic workforce plan for the acquisition workforce in 2012, but has not yet done so, in part, according to DOD, because of the uncertainty regarding future budgets. We met with the newly named Director of that office in January and March 2015 as part of an ongoing acquisition workforce review. The Director is aware of the reporting requirement, but it remains unclear when DOD will issue the biennial plan.

c. In regards to Operational Contract Support, you referenced a 2012 study that found DOD was short about 70 positions related to civilian operational contract support analysts and planners. To the best of your knowledge has DOD been successful in completing its contract support without these 70 positions?

Our prior work identified a number of challenges with regard to planning for operational contract support (OCS) that could be due in part or exacerbated by the shortages of civilian OCS analysts and planners that was highlighted in DOD's 2012 OCS Manpower Study.[15] For example, in February 2013, we found that while the Defense Logistics Agency, at the request of the combatant commands, has provided analysts with planning expertise to aid combatant commands in integrating OCS into their operations planning, the combatant commands' military service components have not been provided such expertise to aid them in meeting their OCS planning requirements.[16] Without this expertise, we found that component planners are limited in their ability to integrate OCS into their plans to support combatant command requirements and, in some cases, are unaware of the overall requirements to integrate OCS into their planning as directed by the combatant commander. As a result, the components face difficulties incorporating OCS considerations into their planning efforts. This level of planning is essential since components generally identify and provide the resources necessary to support the combatant command's requirements in order to accomplish the mission of the specific operation.

Further, DOD is implementing an OCS mission integrator concept. According to DOD documentation, the OCS mission integrators will be located at the combatant commands, joint task forces or selected components and will serve as an enduring, scalable cell, capable of providing the combatant command, subordinate joint force

[15]Department of Defense, Operational Contract Support Manpower Study (Sept. 2012).
[16]GAO, Warfighter Support: DOD Needs Additional Steps to Fully Integrate Operational Contract Support into Contingency Planning, GAO-13-212 (Washington, D.C.: Feb. 8, 2013).

commander, or selected service components a single lead for all major OCS efforts spanning current operations, future operations, and future planning.[17] While it may prove challenging to establish OCS mission integrators in an era of constrained resources, U.S. Pacific Command has begun partnering with the Joint Staff (J-4) to implement the OCS mission integrator concept in an operational environment.

[17]Department of Defense, Operational Contract Support Joint Concept (Oct. 7, 2013).

Post-Hearing Questions for the Record
Submitted to the Honorable Gene L. Dodaro
From Senator Kelly Ayotte

"Risky Business: Examining GAO's List of High Risk Government Programs"
February 11, 2015

1. **According a December 2014 Inspector General report, the IRS estimates that $14.5 billion or 24 percent of all earned income tax credit (EITC) payments made in 2013 were paid in error. And for the additional child tax credit, the IG estimates that the potential improper payment rate for 2013 is between 25.2 and 30.5 percent, with potential improper payments totaling between $5.9 and $7.1 billion. Would expanded authority to allow the IRS to make corrections to tax returns when data obtained from the Department of Health and Human Services indicate the taxpayer's refundable credit claims are not valid help reduce improper payments?**

   We have identified several situations where the Internal Revenue Service (IRS) can make corrections to tax returns using math error authority and have recommended broadening IRS's authority, with appropriate safeguards against misuse of that authority.[18] Expanding this authority could help IRS correct additional errors and avoid burdensome audits and taxpayer penalties.

   According to the Treasury Inspector General for Tax Administration (TIGTA), IRS has math error authority to address some erroneous claims, but additional authority to systematically disallow certain erroneous EITC claims with unsupported wages could reduce improper payments.[19] Treasury has proposed expanding IRS authority to permit it to correct errors in cases where information provided by the taxpayer does not match information in government databases among other things.

2. **One area where GAO has identified significant savings is data center consolidation. The federal government operates thousands of underutilized data centers that, if consolidated, could save $5 billion, reduce electricity consumption, and better protect stored information. Last year Congress passed The Federal Data Center Consolidation Act of 2013 (S. 161 1), which required federal agencies to develop data center consolidation and optimization plans. However, legislation only accomplishes what it is supposed to if it is implemented correctly. The fact that infonnation technology acquisitions and management was just added to the High Risk List indicates that things might not be headed in the right direction, especially since over the past five years less than a quarter of 730 GAO**

[18]For details, see GAO, *Tax Filing Season: 2014 Performance Highlights the Need to Better Manage Taxpayer Service and Future Risks*, GAO-15-163 (Washington, D.C.: Dec. 16, 2014).
[19]TIGTA, *Existing Compliance Processes Will Not Reduce the Billions of Dollars in Improper Earned Income Tax Credit and Additional Child Tax Credit Payments* (Washington, D.C.: Sept. 29, 2014).

recommendations have been fully implemented. Like data center consolidations, are there other IT areas that would benefit from congressional mandates and reforms, or is administration implementation a chokepoint?

In adding *Improving the Management of IT Acquisitions and Operations* to our High Risk List,[20] we highlight several critical areas that could improve the federal government's ability to effectively and efficiently invest in information technology (IT). These include, in addition to opportunities for greater savings from data center consolidation, the need for agencies to deliver capabilities incrementally (i.e., in 12-month cycles) to reduce investment risk, improvements needed in the accuracy and reliability of investment cost and schedule data on the IT Dashboard, and the importance of identifying duplicative IT spending and achieving cost savings as part of the Office of Management and Budget's (OMB) PortfolioStat initiative. Immediately preceding the addition of this new area to our High Risk List, in December 2014, Congress enacted federal information technology acquisition reform provisions as a part of the Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act for Fiscal Year 2015.[21] This legislation includes requirements that agencies report to OMB on progress in consolidating federal data centers and achieving associated cost savings, and that OMB provide guidance that requires agency chief information officers (CIO) to certify that IT acquisitions are adequately implementing incremental development and that cost and schedule performance are adequately reflected in evaluations of major IT investments. Further, the law requires that OMB, in consultation with agency CIOs, implement a process to assist agencies in managing their IT portfolios, and that agencies other than the Department of Defense (which has separate requirements) ensure that CIOs have a significant role in programming and budgeting decisions.

The new IT acquisition reform requirements codified in this legislation, if effectively and fully implemented, should further assist in addressing key issue areas identified in our high-risk report related to the management of IT investments. Going forward, OMB and federal agencies should expeditiously implement the requirements of the December 2014 statutory provisions. Doing so should (1) improve the transparency and management of IT acquisitions and operations across the government, and (2) strengthen the authority of chief information officers to provide needed direction and oversight. However, to help ensure that these improvements are achieved, congressional oversight of agencies' implementation efforts is essential.

---

[20]GAO, *High Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).

[21]Carl Levin and Howard P. 'Buck' McKeon National Defense Authorization Act for Fiscal Year 2015, Pub. L. No. 113-291, Div. A, Title VIII, Subtitle D (Dec. 19, 2014).

3. Department of Defense secretary nominee Ash Carter has committed to DoD's current timelines for producing the necessary audit documents. Is GAO satisfied with the pace at which the Pentagon is resolving GAO recommendations in order to meet DoD auditability deadlines?

We acknowledge the commitment of the Department of Defense's (DOD) senior leadership to address its financial management challenges. Specifically, DOD continues its efforts to (1) implement the Financial Improvement and Audit Readiness (FIAR) Plan and the accompanying FIAR Guidance, which provides the standard methodology for DOD's components to achieve audit readiness, (2) implement certain of its planned enterprise resource planning (ERP) systems to establish modern business information systems,[22] and (3) develop training programs to build a skilled workforce. However, the department continues to face challenges in demonstrating progress.

Our recent work has shown that DOD components are not effectively implementing the FIAR Guidance, which can affect not only the department's ability to meet its September 30, 2017, full financial statement auditability goal, but more importantly the department's ability to make lasting improvements in its financial management capabilities. The FIAR Guidance requires DOD components to thoroughly assess key controls over their financial processes, develop corrective action plans, and verify that implementation of these plans successfully remediates system, process, and internal control deficiencies. However, components are asserting audit readiness before completing the key steps required by the FIAR Guidance methodology to ensure that effective processes, systems, and controls are in place for providing financial management information that is sufficient and reliable for day-to-day decision making. For example, we issued two reports to DOD in 2014 with recommendations aimed at improving the implementation of the FIAR Guidance with respect to the Army's budget execution and payments to contractors made by the Defense Finance and Accounting Service (DFAS).

We reported that while the Army and DFAS had asserted audit readiness for the respective financial management processes, they had not effectively completed many of the procedures required by the FIAR Guidance, such as documentation of its end-to-end processes, adequate testing of key controls and documenting remediation of control deficiencies. While time frames are important for measuring progress, DOD should not lose sight of the ultimate goal of implementing lasting financial management reform to ensure that it can routinely generate reliable financial management and other information critical to decision making and effective operations.

Although DOD has implemented some of our recommendations made in earlier reports on its FIAR effort, we have found that the department has not fully implemented many of our recommendations, including those regarding its ERPs and effectively managing risks related to its FIAR Plan. The ERP recommendations are of particular concern because DOD officials have stated that the successful implementation of these ERPs is critical to

[22]An ERP solution is an automated system using commercial off-the-shelf software consisting of multiple, integrated functional modules that perform a variety of business-related tasks such as general ledger accounting, payroll, and supply chain management.

the department's goal of producing auditable financial statements by September 2017. However, several ERPs are not yet functioning and DOD's Office of Inspector General has noted that some ERPs will not be fully deployed by the department's 2017 audit readiness deadline.[23] Moreover, our recommendations pertaining to managing risk with respect to the FIAR Plan are important to help ensure its successful implementation. Without following this disciplined approach, DOD is at increased risk of not effectively achieving its audit readiness goals and lasting financial management reform.

[23]DOD, Office of Inspector General, *Inspector General's Statement of Management and Performance Challenges for FY 2014*, DOD Agency Financial Report for Fiscal Year 2014 (Washington, D.C.: November 2014).

Post-Hearing Questions for the Record
Submitted to Hon. Gene L. Dodaro
From Senator Ben Sasse

"Risky Business: Examining GAO's List of High Risk Government Programs"
Wednesday, February 11, 2015

1. **During your testimony you noted how the Earned Income Tax Credit (EITC) program was susceptible to fraud for a variety of reasons. For instance, the Treasury Inspector General for Tax Administration (TIGTA) estimates that in fiscal year 2013, approximately 24 percent of all EITC payments were made in error.[24]**

    a. **According to the IRS, the agency paid out $5.8 billion in fraudulent returns in 2013. How does the agency distinguish between fraudulent claims and the tens of billions of dollars per year paid out?**

    The Internal Revenue Service (IRS) employs multiple approaches and tools to distinguish between Identity Theft (IDT) returns and legitimate returns. IRS's efforts to combat IDT refund fraud occur at various stages of tax return processing (pre-refund) and continue after it issues tax refunds (post-refund).

    Pre-refund

    IDT and Fraud Filters. IRS uses computerized automatic checks that screen returns using characteristics that it has identified in previous IDT refund fraud schemes. The filters also search for clusters of returns with similar characteristics, such as the same bank account or address, which could indicate potential fraud. Suspicious returns are flagged and taxpayers are contacted to confirm their identities.

    Authenticating Taxpayer Identities. IRS has enhanced its authentication efforts to combat IDT refund fraud. For example, IRS provides Identity Protection Personal Identification Numbers (IP PIN) to past IDT victims who have confirmed their identities with IRS. IRS systems reject returns that lack IP PINs of taxpayers who have been issued an IP PIN.

    Post-refund

    Duplicate returns. Often, IRS becomes aware of IDT refund fraud when a taxpayer alerts IRS of an inability to electronically file (e-file) a tax return. Specifically, in cases where an identity thief has already e-filed a return using another taxpayer's name and Taxpayer Identification Number—such as an SSN—IRS's e-file system will reject the second,

[24] http://www.treasury.gov/tigta/press/press_tigta-2014-50.htm

duplicate return, thus preventing the legitimate taxpayer from filing. IRS officials are aware when the e-file system rejects returns; however, they do not know if the rejections are due to IDT refund fraud unless further investigation is conducted.

Third-party leads. IRS receives third-party leads regarding suspected IDT refund fraud and other types of refund fraud through efforts including the External Leads Program and the Opt-In Program. The External Leads Program involves third parties providing lead information to IRS. If IRS determines a questionable refund is fraudulent, it will request that the financial institution return the refund. The Opt-In Program allows financial institutions to electronically reject suspicious refunds and return them to IRS, indicating why the institution is rejecting the refunds.

Automated Underreporter (AUR) program. IRS also finds IDT refund fraud as part of the AUR program, which matches tax return data to information returns, such as Form W-2. These information returns are provided by third parties such as employers, financial institutions, and others. In many cases, IRS does not receive the information returns until well after receiving tax returns and processing refunds. In these types of cases, the legitimate taxpayer may not be aware of a stolen identity until after receiving a notice indicating that the income (or payment information) IRS has on file does not match the information reported on the tax return.

Criminal investigations. IRS identifies IDT cases as part of its criminal investigations.

b. Are any particular tax benefit programs, or types of programs, more vulnerable to fraud than another?

In general, income and tax benefits that do not have third-party information reporting are more vulnerable to fraud. We have previously found that the extent to which individual taxpayers accurately report their income is related to the extent to which the income is reported to them and IRS by third parties or taxes on the income are withheld.[25] For example, we have reported that for types of income for which there is little or no information reporting, such as business income, individual taxpayers tend to misreport over half of their income. In contrast, employers report most wages, salaries, and tip compensation to employees and IRS through Form W-2. Also, banks and other financial institutions provide information returns (Forms 1099) to account holders and IRS showing the taxpayers' annual income from some types of investments. Findings from IRS's study of individual tax compliance indicate that nearly 99 percent of these types of income are accurately reported on individual tax returns.

[25]GAO, *Tax Gap: Sources of Noncompliance and Strategies to Reduce It*, GAO-12-651T (Washington, D.C.: Apr. 19, 2012).

c. Is the EITC program susceptible to fraud? If so, why?
We have highlighted persistent problems with improper EITC payments for years, and it is a factor underlying our continued designation of Enforcement of Tax Laws as a high-risk area.[26] In fiscal year 2014, IRS reported program payments of $65.2 billion for the EITC[27] and estimated that 27.2 percent, or $17.7 billion, of these payments were improper.[28] The estimated improper payment rate for EITC has remained relatively unchanged since fiscal year 2003 (the first year IRS had to report estimates of these payments to Congress), but the amount of improper EITC payments increased from an estimated $10.5 billion in fiscal year 2003 to $17.7 billion in fiscal year 2014.

As we have reported, a root cause of EITC noncompliance is the self-determination of eligibility by taxpayers (or their preparers) combined with IRS's limited ability to verify eligibility before payments (refunds) are issued. According to Treasury, EITC improper payments can be divided into two categories—authentication and verification.[29] Authentication errors include errors associated with IRS's inability to validate qualifying child requirements, taxpayers' filing status, and EITC claims associated with complex or nontraditional living situations. Verification errors relate to IRS's inability to identify individuals improperly reporting income to erroneously claim EITC amounts to which they are not entitled. Verification errors include underreporting and overreporting of income by wage earners as well as taxpayers who report that they are self-employed. Although the EITC program has been modified a number of times since its enactment in 1975 to reduce complexity and help improve the program's administration, complexity has remained a key factor contributing to improper payments in the program.

---

[26]GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 11, 2015).
[27]EITC eligibility depends on an individual's earned income. Credit amounts depend on the number of qualifying children who meet age, relationship, and residency tests. The credit gradually increases with income (the phase-in range), plateaus at a maximum amount (the plateau range), and then gradually decreases until it reaches zero (the phase-out range).
[28]EITC overpayments are the difference between the EITC amount claimed by the taxpayer on his or her return and the amount the taxpayer should have claimed. EITC underpayments are defined as the amount of EITC disallowed by IRS in processing that should have been allowed.

[29]Treasury Inspector General for Tax Administration, *Existing Compliance Processes Will Not Reduce the Billions of Dollars in Improper Earned Income Tax Credit and Additional Child Tax Credit Payments*, Reference Number 2014-40-093 (Washington, D.C.: Sept. 29, 2014).

d. You mentioned that "reduced staffing" at the IRS has contributed to reduced tax enforcement. How many employees does the IRS dedicated to tax enforcement?

IRS's enacted fiscal year 2015 enforcement appropriation funded 40,564 full time equivalents (FTE). This accounts for almost half of IRS's total 82,203 FTE in fiscal year 2015.

FTEs within IRS's enforcement appropriation have declined by 6,797 from 47,361 in fiscal year 2009 (actual) to 40,564 in fiscal year 2015 (enacted).

e. Your testimony said the Internal Revenue Service (IRS) dedicates 3,000 employees to detecting and preventing identity theft. What do these employees do and is it enough?
Employees work to prevent refund fraud, investigate IDT-related crimes and help taxpayers who have been victimized by identity thieves.

Given that IRS estimates that it paid $5.8 billion in refunds of the $30 billion in attempted IDT refund fraud in filing season 2013, more effort is needed to combat the problem. In particular, IRS will need to focus on developing a robust pre-refund strategy because preventing fraudulent refunds is easier and more cost-effective than trying to recover refunds after they have been issued. Preventing IDT refund fraud could also allow IRS to reallocate FTEs dedicated to resolving IDT on tax accounts to other needs.

We have reported on two potential tools (improved taxpayer authentication and pre-refund Form W-2 matching) that could prevent billions in IDT refund fraud; however these tools would have significant costs for taxpayers and IRS and would require substantial changes in tax administration.[30] See Question 1h below for details on our recommendations related to taxpayer authentication and pre-refund Form W-2 matching.

f. How many IRS employees are responsible for overseeing and enforcing the Patient Protection and Affordable Care Act?
Under IRS's fiscal year 2015 budget, approximately 1,200 FTEs are responsible for implementing the Patient Protection and Affordable Care Act.

---

[30]GAO, *Identity and Tax Fraud: Enhanced Authentication Could Combat Refund Fraud, but IRS Lacks an Estimate of Costs, Benefits and Risks*, GAO-15-119 (Washington, D.C.: Jan. 20, 2015) and *Identity Theft: Additional Actions Could Help IRS Combat the Large, Evolving Threat Of Refund Fraud*, GAO-14-633 (Washington, D.C.: Aug. 20, 2014).

g. **If millions of additional people become eligible for EITC benefits as a result of the President's executive actions on immigration, will the IRS need additional people to fight identify theft?**
At this time, we do not know how often the EITC is claimed on IDT returns, or if IDT returns claim the EITC more often than other types of tax credits. As part of an ongoing engagement, we will review the characteristics of IDT refund fraud, including the types of credits that were claimed.

h. **Why has the IRS not yet complied with GAO's recommendations for reducing fraud and identity theft?**
IRS has implemented several of our prior recommendations, and agency officials have told us they are implementing outstanding recommendations from our recent reports. For example:

- In November 2012, we recommended several improvements to IRS's *Refund Fraud and Identity Theft Global Report*, which consolidates and tracks information about IDT incidents across multiple sources within IRS.[31] In June 2013, IRS updated the *Global Report* to improve the reliability of IDT information available to Congress and IRS management.

- In August 2014, we recommended that IRS estimate the costs and benefits of pre-refund Form W-2 matching, including identifying the IRS systems that will need to be adjusted and providing information on other changes will be needed (such as delaying the start of the filing season or delaying refunds).[32] In November 2014, IRS reported that it had convened an internal working group to address our recommendations and that it anticipated implementing our recommendations by July 2015.
We also recommended that IRS improve feedback to third parties by (1) providing aggregated information on the success of external leads in identifying suspicious returns and emerging trends and (2) developing metrics to track external leads by the submitting third party. In November 2014, IRS reported that is developing a methodology for implementing our recommendations and anticipates implementing them by November 2015.

- In January 2015, we recommended that IRS improve its IDT refund fraud estimates by (1) reporting the inherent imprecision and uncertainty of estimates and (2) documenting the underlying analysis

[31]GAO, *Identity Theft: Total Extent of Refund Fraud Using Stolen Identities is Unknown*, GAO-13-132T (Washington, D.C.: Nov. 29, 2012).

[32]GAO, *Identity Theft: Additional Actions Could Help IRS Combat the Large, Evolving Threat Of Refund Fraud*, GAO-14-633 (Washington, D.C.: Aug. 20, 2014).

justifying cost-influencing assumptions.[33] We also recommended that IRS estimate the economic costs, benefits, and risks of possible options for taxpayer authentication. IRS agreed with our recommendations. We anticipate receiving IRS's plan for implementing these recommendations in April 2015.

[33]GAO, *Identity and Tax Fraud: Enhanced Authentication Could Combat Refund Fraud, but IRS Lacks an Estimate of Costs, Benefits and Risks*, GAO-15-119 (Washington, D.C.: Jan. 20, 2015).

○